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AUTHOR Glen, Sally S.; McCoy, Youlonda H.
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ABSTRACT

Part of a three-part series depicting training approaches for paraprofessionals working with handicapped children, the booklet focuses on two major competencies: general understandings of special education and of major handicapping conditions. This module is intended for paraprofessionals who have had little experience with, and/or education about, special needs children. Each competency consists of objectives which are further broken down into activities with suggested times for each activity. The first competency is addressed in terms of definition of key terms, historical developments in special education (including information on relevant legislation), the paraprofessional's role in identification and assessment, and the individualized education program. Competency 2 focuses on general information on characteristics and teaching strategies for children with seven handicapping conditions: mental retardation; hearing impairments; speech and language impairments; orthopedic and health impairments; emotional handicaps; learning disabilities; and visual impairments. Handouts and mini-lectures are provided for competency objectives. (CL)

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ORIENTATION TO HANDICAPPING CONDITIONS
LEVEL I

Training Module

by

Sally S. Glen

and

Youlonda H. McCoy

LEARNING AND EDUCATION FOR EXCEPTIONAL PARAPROFESSIONALS (LEEP)
NORTH CAROLINA A&T STATE UNIVERSITY
Greensboro, North Carolina

LEARNING AND EDUCATION FOR EXCEPTIONAL PARAPROFESSIONALS

North Carolina A&T State University
Greensboro, North Carolina 27401

A three year project funded by Special Education Programs to train paraprofessionals to work with handicapped children. Training activities stressed the attainment of competency-based skills.

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SUGGESTIONS FOR CONDUCTING TRAINING SESSIONS

Before the Training Session

1. Familiarize yourself with the module. Read the module in order to learn the content of the module. Be familiar with the contents (activities and directions) to prevent stumbling during the training session.

2. Find out the needs of the trainees, their strengths and weaknesses and the amount of time you will have for training.

3. Adapt the module to fit the needs of the trainees and the time designated for training (e.g., four one-hour sessions, two four-hour sessions). Decide which parts of the module you will use.

4. Schedule a location for the training session. Be sure the room will lend itself to training activities--e.g., blackboard or chart; room can be darkened, enough seating and space for trainees, location of outlets.

5. Decide which audiovisual materials (films, videocasettes) will be needed so that they can be ordered.

6. Reserve audiovisual equipment needed. If possible, check to see that it works. Remember special items such as adaptors, extension cords, take-up reels, extra projector bulbs.

7. Adapt and/or reproduce all handouts needed. If possible, color code them for clarity.

8. Revise the training format to reflect your own training style and presentation plans. Make notes in the margins next to the activities.

9. Become familiar with local resources. Identify agencies, consultants, etc., to inform trainees of local contacts.

10. (Optional) Obtain folders or notebooks for trainees' handout materials. Handouts tend to get scattered if not kept in one place.

11. Review, if necessary, some basic principles of adult learning and training techniques.

12. Develop or adapt an evaluation form to use at the completion of the training session.

During the Training Session

1. Set the stage. If trainees do not know each other, use a few introductory ice- breaker activities at the beginning.

2. Use relaxed training approach. Create a "learning can be fun" attitude to help trainees feel free to participate.

3. Provide in-house rules, if appropriate--e.g., use of the bathroom, getting coffee if it is provided, etc.

4. Review the handouts, if they have been given as a packet of materials, to ensure trainees have all of them.

5. Have all the materials needed for training on hand--e.g., magic markers, newsprint, chalk, audiovisual equipment, handouts, etc.

6. Elicit participation from trainees as soon as possible.

7. Observe the trainees for signs of involvement or lack of involvement. Be attuned to their needs and build in short breaks or change of pace of the activities.

8. Be aware some trainees may monopolize the discussion or digress from the subject. Trainer should include all trainees in discussing and help them adhere to the topic.

9. Introduce audiovisual presentations with preview questions to provide the trainees with guides for viewing the audiovisuals.

10. Make notes as you proceed to help in planning future training sessions. Note areas of confusion, activities that may need to be revised.

11. Use an evaluation form at the end of the workshop to obtain feedback from the trainees.

After the Training Session

1. Straighten the room--e.g., erase the blackboard, empty ashtrays, turn off the lights.

2. Return borrowed audiovisual equipment and materials.

3. Follow-up on requests for additional information from trainees.

4. Incorporate trainees' comments from the evaluations into future training designs.

5. Do a self evaluation of the workshop. What were its strengths and weaknesses?

6. Complete workshop correspondence. Write thank you letters to any consultants used in the workshop.

7. File the training design and a roster of participants so that you will have it available if needed.

INTRODUCTION AND OVERVIEW

Orientation to Handicapping Conditions: Level One is a training module designed for use with paraprofessionals in public schools and child care settings who work with handicapped children. As a result of PL 94-142, handicapped children are being served in the least restrictive environment. Thus, paraprofessionals need help in learning to understand and accept these special needs children.

This module is divided into two major competencies. Competency I focuses on a general introduction to special education. It includes definitions of frequently used terminology, differences in special education and regular education services, and a historical progression of special education, including legislation that has affected special education. Brief descriptions of the Individualized Education Program and screening and assessment techniques are also included.

Competency II describes each of the major handicapping conditions. The paraprofessional is provided with characteristics, causes, and educational strategies as well as resources where he/she can go for assistance.

Orientation to Handicapping Conditions: Level One is designed for the paraprofessional who has little experience and/or education with special needs children. Including the paraprofessional in open, supportive, and thoughtful sessions, the module is based on the philosophy that paraprofessionals must be actively involved in their learning for it to be effective. For more advanced paraprofessionals (those with education and experience/training), Orientation to Handicapping Conditions: Level Two may be more appropriate.

Each competency consists of objectives which are the focal points of the training. Each objective is divided into activities with suggested times for each activity. The suggested times given after each activity are provided to give the trainer a sense of the overall scheduling of the module. The trainer should vary time lengths based on the needs and interests of the group.

COMPETENCY 1:

Develop a Special Knowledge of Special Education

OBJECTIVE 1.0

Competency I: Develop a General Knowledge of Special Education

Objective 1.0	Content	Activities	Time	Pre/Post Questions
13 To define special education and explain how it differs from regular education services.	I. Definitions of key terms A. Handicapped child 1. Special needs child 2. Exceptional child B. Special Education C. Least restrictive D. Mainstreaming E. Related Services F. IEP G. Disability H. Handicap II. Differences in special education and regular education services	Small Group Activity: Trainees divide into small groups and complete HANDOUT: Key Terms Used In Connection with Special Education. Large Group Activity: Small groups share completed definition with large group. Trainer assists in clarifying definitions. Mini-Lecture: Key terms used in connection with special education. Handout: Definitions of some special education terms. This is used to reinforce the mini-lecture. Brainstorming and Group Discussion: Differences between special education and regular education. Handout: First steps in mainstreaming.	10" 10" 10" 5" 15"	14 Exceptional children and youth are those individuals: a. who were born with an impairment but do not require special educational services b. who need special educational programs, services, facilities or materials to enable them to reach their full potential c. who must be educated in the home because of a severe impairment d. who do not receive educational services (in home or school) because of severe impairment(s) Labeling children in special education categories is helpful for planning individualized education programs and for obtaining federal and state funds. true/false Under PL 94-142, many handicapped children will be mainstreamed. "Mainstreaming" is:

Competency I: Develop a General Knowledge of Special Education

Objective 1.0	Content	Activities	Time	Pre/Post Questions
continued				a. a plan whereby all handicapped children will be taught in neighborhood schools rather than in special schools b. the practice of ensuring that handicapped children will be taught vocational skills so that they can support themselves after their education is complete. c. the placement of handicapped children in regular classrooms all or part of the day, if this is the most appropriate approach for educating an individual child. d. a plan which will eventually incorporate all handicapped children into regular classrooms.

MINI-LECTURE

Key Terms Used in Connection with Special Education

(Major Resources: Federal Register, Vol. 42, No. 163, PL 94-142: Education for All Handicapped Children Act of 1975.

94-142 and 504: Numbers that Add Up to Educational Rights for Handicapped Children, Children's Defense Fund of the Washington Research Project, Inc., 1520 New Hampshire Avenue, NW, Washington, DC 20036.)

The Education for All Handicapped Children Act of 1975 (PL 94-142) identifies handicapped children as those children, aged 3-21 years, identified as hearing impaired, speech impaired, visually impaired, emotionally disturbed, mentally retarded, physically impaired, learning disabled or suffering from other health impairments. Local or regional names for these handicapping conditions vary, so it may be that in some areas, mentally retarded individuals are referred to as mentally handicapped, emotionally disturbed as emotionally impaired, and so on.

Under PL 94-142, special education is clearly defined as "specially designed instruction, at no cost to parent, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions." The law mandates that each handicapped child is entitled to effective instruction in reading, writing, speaking and arithmetic--all basic skills necessary for self-sufficient living. However, under 94-142, special education involves more than classroom teaching designed for children with special learning problems. It also includes:

- Early identification and assessment of disabilities
- Specially trained teachers and teachers' aides
- Speech and language therapy
- Special materials and equipment
- Counseling
- Psychological services
- School health services
- Medical services for diagnostic or evaluation purposes
- Physical education and athletic programs
- Physical therapy
- Special transportation to school and activities within school
- Extra-curricular and after-school activities
- Vocational education
- Employment services
- College placement services
- Parent counseling and special homemaker services that teach

natural and foster parents how to care for handicapped children

- Other programs and services deemed necessary for the handicapped child's education

Special education services can take place in a variety of settings. The needs of each student must be taken into account before any educational placement is made. The term used under PL 94-142 to describe the major guide for student placement is the least restrictive environment. The concept of least restrictive environment implies that the child will be educated in the setting which most allows him to function in the real world, with all kinds of children. For some students, this would mean placement in regular education classrooms with nonhandicapped children of the same age range. For other students, a combination of special education and regular education classrooms will be more appropriate. Some severely handicapped children will benefit most from placement in a special education classroom or a residential educational setting. The law states that "1) to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped and 2) that special classes, separate schooling, or other removal of handicapped children from the regular education environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."

Mainstreaming is a term which has come to be used to describe placement of handicapped children in the least restrictive environment, usually with nonhandicapped children. In some cases, use of the term "mainstreaming" has come to be associated with the placement of all handicapped children in regular classrooms; however, the principle of mainstreaming is a complex one which provides a variety of options designed to provide a suitable learning environment for each student. As described above, this may or may not mean that handicapped students are placed in regular education classrooms all or part of the day.

PL 94-142 identifies a variety of related services which are to be provided to complete the educational process of handicapped students. Most of these related services have been mentioned, but the law specifically references and defines specific services which should be provided as necessary to meet the educational goals of a particular student. These include: transportation and developmental, corrective and other supportive services required to assist the child in benefiting from special education such as speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes, school health services, social work services in schools, and parent counseling and training.

KEY TERMS USED IN CONNECTION WITH SPECIAL EDUCATION

Based on your current knowledge of special education and PL 94-142, define, in your small group, the following terms as they apply to the education of handicapped children.

Handicapped children:

Special needs children:

Exceptional children:

Special education:

Least restrictive environment:

Mainstreaming:

Related services:

Individualized Education Program:

Disability:

Handicap:

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HANDOUT

Definitions of Some Special Education Terms

Special Education: This is a special or unique educational service over and above regular education needed by the handicapped child. Special education includes trained teaching personnel, special curriculum, and special facilities and equipment.

Exceptional Child: This is the child whose educational requirements are so different from those of the average or normal child that he cannot be effectively educated without the provision of special education programs, services, facilities, or materials. This broad category generally includes the handicapped child as well as the gifted or creative child.

Special Needs Child: This is a child who differs physically, intellectually, socially or emotionally to the extent that some modification of the regular school program is often necessary to enable them to reach their full potential.

Impairment: A deterioration, partial loss of functioning, etc., due to a disorder or disease, e.g., hearing impairment.

Disability: A physical, emotional, or neurological deviation in an individual's development. The disability may form a handicap; however, not all disabilities constitute handicaps.

Handicap: The result of any condition or deviation from the norm (physical, psychological, environmental, and/or learning) that hinders or prevents an individual's acceptance, adjustment or achievement.

HANDOUT

First Steps in Mainstreaming

(Resource: Tips on Mainstreaming: Do's and Don'ts in Activity Programs. American Alliance for Health Physical Education and Recreation, Washington, DC, Vol. 1, No. 10, March 1978.)

Regardless of an individual child's specific condition, various strategies exist for introducing and improving relationships between handicapped and nonhandicapped children. For example:

- Arrange with parents for special needs and non-special needs children to play together outside of school.
- Individualize the curriculum for all children, not just special needs children.
- Establish respect for individuals as the prime classroom value.
- Create a safe, protected environment so that children can risk forming relationships.
- Explain individual differences to children in a neutral, value-free manner.
- Read aloud books and stories that deal with differences.
- Answer children's questions directly and honestly.
- Reinterpret actions for children in behaviorally observable terms--e.g., "His legs don't work very well," or "It's hard for him to hold your hand without squeezing it."
- Encourage children to use behavioral explanations rather than labels.
- Design and guide positive interactions between children based on a common interest or curricular experience.
- Encourage all children to talk about feelings such as fear and anger--and help them begin to understand and govern these emotions.
- Encourage spontaneous dramatic play and role playing to help nonhandicapped children identify with the experience of special needs children--e.g., using crutches, walkers, hearing aids, crawling or limping.

- Create opportunities for all parents to meet with each other to discuss their reactions to mainstreaming.*

*Based on First Steps in Mainstreaming: Some Questions and Answers, by Samuel J. Meisels, Media Resource Center, Massachusetts Department of Mental Health, March 1977.

COMPETENCY I:

Develop a Special Knowledge of Special Education

OBJECTIVE 2.0

Competency I: Develop a General Knowledge of Special Education

Objective 2.0	Content	Activities	Time	Pre/Post Questions
To briefly outline the historical progression of educational services for handicapped individuals, including current legislative bases for the provision of special education services.	I. Historical Development A. Influence of superstition B. General trends before mid-1700s C. Beginning of residential schools for the blind and deaf D. The 19th Century Age of Institutions E. Beginnings of special education in the public schools F. Trends: 1920-1960 II. Legislation Affecting Special Education A. Section 504 B. PL 94-142 C. The Creech Bill	Mini-Lecture: The Historical Development of Special Education. Film: Exceptional Times: An Historical Perspective of Special Education Group Discussion: The effect of attitudes toward handicapped individuals on services and special education. Mini-Lecture: Overview of Special Education Legislation. Handout: Public Law 94-142.	20" 20" 15" 15" 10"	As regards special education, the 19th century was the age of: a. tyranny b. institutions c. special education classes in the public schools d. repression (b) Section 504 of the Vocational Rehabilitation Act of 1973 mandates program accessibility for federally funded activities. true/false (true) PL 94-142 provides for a "free appropriate education" only for handicapped children who can be served in the public schools. true/false (false) In North Carolina, the law mandating state implementation of federal legislation is: a. The Creech Bill b. The NC Education for All Handicapped Act c. The Harper Amendment d. The Special Education Amendment of the Education Act of 1977 (a)

MINI-LECTURE

The Historical Development of Special Education

(Major Resource: Gearheart, Bill. Special Education for the '80s, The C. V. Mosby Company, St. Louis, 1980.)

The treatment accorded persons with disabilities has varied widely throughout history. Although a variety of handicapping conditions have been recognized for centuries, specific educational services for individuals with these disabilities is a relatively recent phenomenon. One reason for this has been the way society has reacted to these handicaps--reactions have varied from fear, to suspicion, or to reverence as disabled persons were viewed as possessed by demons, being punished for some heineous sin, or as endowed with special gifts or insights.

Prior to the mid-1700s services to handicapped individuals fluctuated between more scientific approaches and humanitarian desires to be of service to less fortunate persons and the superstitious fear of the unknown causes and implications of disabilities. At times, incarceration, torture, and even death were not uncommon fates for the disabled. Then, in the middle of the eighteenth century, schools for the deaf and blind of all social classes were opened in France and Germany. England followed in offering educational programs for deaf and blind students later in the 18th century, and in the early 1800s began similar programs for the mentally retarded. As these programs began to prove that handicapped individuals could benefit from educational services, they began to spread to the United States. As a result, the nineteenth century has been recognized as the first to offer a century-long, organized effort to train or educate the handicapped.

The 19th century saw the rise of a number of "asylums" or "institutions" for the deaf and residential schools for the blind and mentally retarded. At the same time, Dorothea Dix, advocating for the rights of mentally ill persons, was responsible for the establishment of thirty-two modern mental institutions. During this time, although rapid improvements were made in the types of educational opportunities available to disabled individuals, these services were primarily provided in segregated settings. Residential facilities, for the most part, served both children and adults and were supervised by medical personnel.

Through the efforts of Dr. Alexander Graham Bell and other pioneers in special education, the Department of Special Education, designed to facilitate education of handicapped students in the public schools, was made a part of the National Education Association (NEA) in 1902. This began the development of the self-contained special education classroom--although the quality and focus of special education practices varied widely from jurisdiction to jurisdiction, depending on state laws.

Between 1920 and 1960, self-contained classes for the educable mentally retarded and physically handicapped grew in popularity, while the trainable mentally retarded (those with IQs under 50) were often denied educational opportunities. At the same time, residential schools for mentally retarded individuals not being serviced in the public schools became more numerous, as did residential facilities for deaf and blind students. For the most part, the latter were more educationally oriented than residential facilities for the retarded. In some cases, specially modified classrooms designed for use by physically handicapped students began to be replaced by special schools. Thus, through the first half of the twentieth century, while services for handicapped students within the public school system expanded, in many cases expansion of these services lead to a growth in segregated and residential schools and educational programs.

Beginning in the mid-1960s, societal pressure by parent groups and other advocates for the rights of handicapped individuals led to a variety of legislative acts related to special education and services for disabled individuals. These, in turn, provided the framework for two of the most important legislative actions related to the rights of disabled individuals—Section 504 and PL 94-142.

MINI-LECTURE

Special Education Legislation

(Major Resource: Gearheart, Bill. Special Education for the '80s, The C. V. Mosby Company, St. Louis, 1980.)

In the last few years, alternative ways to meet the education and social needs of the handicapped have become an important issue before the United States Congress. Congressional action resulted in the passage of two laws: one that addresses bringing handicapped individuals into the mainstream of society, and another which provides money and guidelines for the education of disabled individuals.

Section 504 of the Rehabilitation Act (PL 93-112) was signed in 1973. It is the first civil rights law protecting handicapped people of all ages. Intended to bring handicapped people into the mainstream of American life, Section 504 prohibits discrimination on the basis of a physical or mental handicap in every federally-aided program or activity in the country. It requires that programs be as accessible for the handicapped as they are for the nonhandicapped. Because the final development and implementation of the regulations did not take place until 1977, they were similar to and complement those of PL 94-142.

The Education for All Handicapped Children Act (PL 94-142) was signed in 1975. It is a comprehensive legislation relating to public school education and guarantees handicapped children a "free appropriate public education" in the "least restrictive environment." Basically, the law means that a variety of free educational programs and services will be available to meet the unique needs of handicapped children, and these children will be educated as much as possible with nonhandicapped children. PL 94-142 is a public school mandate that applies to children between the ages of 3 and 21 who require special services. The law mandates specific placement options which allow the education of handicapped students in the most appropriate setting--whether in regular or self-contained classrooms--and the availability of a variety of "related services" as necessary to help the child benefit from special education. PL 94-142 also calls for the development of an individualized education plan (IEP) for each handicapped child which outlines specific educational goals and the means of meeting those goals during a specific period of time.

Each state must enact its own legislation related to federal mandates. In North Carolina, the Creech Bill (House Bill 824), which was signed in 1977, is the law that attempts to make state regulations consistent with

federal legislation. The Creech Bill provides for a free, appropriate publicly supported education to every child with special needs (including gifted and talented students) between the ages of five and eighteen.

Copies of PL 94-142 regulations (42 Federal Register 42474, et. seq.) can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (45¢ per copy). The Section 504 regulations (42 Federal Register 22676, et. seq.) can be obtained from the U.S. Department of HEW, Office for Civil Rights, 330 Independence Avenue, SW, Room 5400, Washington, DC 20201.

HANDOUT

Public Law 94-142

Public Law 94-142 makes a number of critical stipulations which must be adhered to by both the state and its localities.

These stipulations include:

- assurance of extensive child identification procedures
- assurance of "full service" goal and detailed timetable
- a guarantee of complete due process procedures
- the assurance of regular parent or guardian consultation
- maintenance of programs and procedures for comprehensive personnel development including inservice training
- assurance of special education being provided to all handicapped children in the "least restrictive" environment
- a guarantee of policies and procedures to protect the confidentiality of data and information
- assurance of the maintenance of an individualized program for all handicapped children
- assurance of an effective policy guaranteeing the right of all handicapped children to a free, appropriate public education, at no cost to parents and guardian
- assurance of a surrogate to act for any child when parents or guardians are either unknown or unavailable, or when said child is a legal ward of the state

HANDOUT

Parent and Child Rights in PL 94-142

As a parent of a handicapped child, the following rights are provided through the new law 94-142.

1. A free, appropriate public education in the least restrictive environment with related services to meet the particular child's need (i.e., speech therapy, physical therapy, counseling, and transportation).

2. Prior information about pre-placement evaluation and right to give and withhold permission for screening and/or evaluation.

3. An explanation of all evaluation results and explanation of any action proposed or rejected in regard to evaluation results.

4. Right to request independent evaluation and have results considered in placement discussion.

5. Right to inspect all records and request explanation of information contained in the record.

6. Right to expect confidentiality of all records. Right to request amendment of child's school records.

7. Right to request a due process hearing at any time when parent disagrees with the proposed procedures for evaluation and/or placement of their child.

8. Right to have counsel, present evidence, and cross examine witnesses and obtain written findings of hearing.

9. Right to have all conferences or hearings interpreted in the event of deafness, or given in parents native tongue.

COMPETENCY I:

Develop a Special Knowledge of Special Education

OBJECTIVE 3.0

Competency I: Develop a General Knowledge of Special Education

Objective 3.0	Content	Activities	Time	Pre/Post Questions
To describe the process of identifying and assessing a handicapped child and the paraprofessional's role in that process.	I. Definitions of key terms A. Screening 1. Yearly 2. Continuous B. Referral C. Assessment II. The importance of screening A. Kinds of screening B. Role of the parents III. Making a referral IV. Assessment A. Types of assessment B. Role of the paraprofessional	Brainstorming: Definitions of key terms used in the screening and assessment process. Handout: Key terms used in the screening and assessment process. Trainer assists in clarifying definitions. Mini-Lecture: Ways to Identify Handicapped Children. Group Discussion: Parent's role in screening. Trainer leads discussion on why we should involve parents in the screening. Discussion should focus on fact that parents have a right to know what goes on with their child. Handout: When should a student be referred. Small Group Activity: Make a referral list. Trainees divide into small groups and list resources for assessment and services at the local, county, state, and national levels. Handout: Resources for assessment and services. Mini-Lecture: Types of assessments. Handout and Discussion: How teacher aides can use test in-	10" 5" 10" 5" 10" 10" 10" 15"	Formal assessment tests can be given by the paraprofessional. true/false (false) Continuous screening refers to: a. the practice of compiling baseline data on a particular disability area throughout a child's academic career b. using observation checklists and other methods to look at all areas of a child's development c. medical procedures under which the child is closely observed for two 24-hour periods within 48 hours between observations d. Monitoring of the child's academic progress throughout the year (b) Parents should be involved in the referral process. true/false (true) Under PL 94-142, handicapped children must be given IQ tests yearly. true/false (true)

HANDOUT

Key Terms Used in the Screening and Assessment Process

Screening:

Yearly screening:

Continuous screening:

Referral:

Assessment:

MINI-LECTURE

Ways to Identify Handicapped Children

There are various methods of identifying and evaluating a child's current developmental skills so that appropriate activities can be utilized for him. The interdisciplinary approach, involving persons from the field of education, psychology, and health care, provides the most complete assessment about a child's special needs.

Let's take a brief look at the steps involved in identifying handicapped children.

The first step is screening. Screening means observing children to see if there are any who have problems and who need to be referred for professional assessment. It is one of the most important responsibilities of those who work with children. Screening is not intended to diagnose problems; the purpose is to sort out or identify the children who are having trouble in some area of development. These children are then referred to professionals who are trained to diagnose problems and identify handicaps.

Screening is important because it is often the first step to a child's receiving help. The earlier the help, or intervention, the better the chance the child will have to improve, and the less the problem will interfere with the child's learning. This is why as children enter day care at an earlier age, more emphasis should be placed on screening.

There are two types of screening. The first type, yearly screening, is for specific problems such as medical, hearing, visual, and speech problems and should be included as a part of the Screening Program. Yearly screening is usually done by a professional. There are four types of yearly screening:

1. Medical screening should be conducted by a physician before a child enters any type of center or home-based program. A medical form completed by the child's physical is required for enrollment in licensed child care programs and in public schools.

2. Auditory screening should be provided for all young children and older children whenever a problem is suspected. This screening is usually done by an audiologist, nurse, speech pathologist, or a health aide trained to use an audiometer.

3. Visual screening should also be provided for all children and is usually done by a nurse, health aide, or someome trained to do visual screening.

4. Speech screening should be provided for all children by a speech pathologist or therapist.

Yearly medical, visual, hearing and speech screening is an important way of identifying possible problems. However, there are some drawbacks to relying only on a "once a year" approach to identifying problems which may affect a child's ability to learn. This type of screening is usually done by someone who is a stranger to the child and sees the child only briefly. Children, particularly young children uncomfortable with strangers, may not act in a typical manner. Sometimes children simply do not respond, and the results of screening are not valid. Additionally, while problems which exist at that time of screening may be identified, other problems may develop later. For these reasons, it is important for persons involved in the handicapped child's education to understand the importance of their observations and to conduct their own screening as well. You do make a difference.

A second type of screening is continuous screening. Continuous screening means looking at all areas of the child's development, such as general health, behavior or social, and self-help, and is for the purpose of referring a child who may need further in-depth assessment. This type of screening can be done by the teacher and/or aide and should be an ongoing part of the program. Various types of screening methods are: observation, checklists, and commercial screening instruments. Some require no special training to administer, while others are more complex and require considerable knowledge and skill before being given.

HANDOUT

When Should a Student Be Referred

(Source: Texas Department of Human Resources. "When You Care for Handicapped Children," Austin, Texas, 1979, p. 13.)

Screening can often pick up students who need more assessment. The following are some guidelines your teacher used when referring a student to a specialist.

1. Always have a clear reason for referring a student. Never refer a student on guesswork. Be able to state specifically why the student needs to be referred.

2. Use a screening instrument to help define your reason for referral.

3. Consider the cultural background and experience of the student. Screening results will not be accurate if the screening instrument used includes items the student has not been exposed to.

4. The results of the screening should reflect the student's problem.

5. Always disuss the results of the screening and the possibility of a referral with the student's parents.

6. Information about the student and the parents is confidential.

HANDOUT

Resources for Assessment and Services

Local Agencies and Service Organizations

- Associations for children with handicapping conditions, e.g., learning disabilities, mental retardation, visual impairments
- Chamber of Commerce
- Men's Clubs (Lions, Kiwanis, Jaycees)
- Women's Clubs (Business and Professional Women's, Jaycettes, etc.)
- PTA
- Church groups (Council of Churches)
- Salvation Army
- Goodwill
- YMCA/YWCA
- Pediatricians and other specialists
- Parent groups
- Local university and colleges
- Local public schools
- March of Dimes
- City parks and recreation programs

County Agencies

- County health department
- County hospital
- County child welfare
- Family service agencies
- Child guidance centers
- Adult education programs
- County judge
- United Way

State and National Agencies and Organizations

- Associations for children with handicapping conditions, e.g., learning disabilities, mental retardation, visual impairments
- Vocational rehabilitation agencies
- Department of Education
- Regional service centers
- Mental health, mental retardation centers
- Social Security Administration (SSI)
- Department of Human Resources
- Commission for the Blind
- Commission for the Deaf
- State schools for deaf, blind, mentally handicapped
- Child Find/Child Serve
- Council for Exceptional Children

MINI-LECTURE

Types of Assessment

After the students in your classroom have been screened, some of them may be referred to an appropriate specialist for further testing. Teacher aides do not assess students, but they should be familiar with the types of assessment that can occur.

To get a total picture of a child's strengths and weaknesses, a combination of formal and informal assessment is necessary.

Formal Assessment

- Tests must be given by a qualified assessment professional.
- Uses standardized psychological tests.
- Test results can be used to identify children with problems.

Informal Assessment

- Teachers and aides with no special training can use checklists or make observations.
- Uses checklists and other kinds of instruments that may or may not be standardized and may include informal assessment.
- Children are not identified as handicapped only on the basis of informal checklists. Children are referred for formal assessment.

MINI-LECTURE

How Teacher Aides Can Use Test Information

There is a great deal of valuable information that you can get from test results. You can use this information in several ways:

1. **To Understand How a Student Learns:**

   - Does the student learn better by hearing something or seeing it?
   - Does the student respond better verbally or through movement (motor)?
   - Does the student learn quickly or is there a need for lots of repetition?
   - Does the student learn better in groups or individually?

2. **To Identify Physical, Emotional, or Social Problems:**

   - Is there a physical problem?
   - Does the student get along well with others?
   - Does the student need lots of support from you or is the student independent?
   - Does the student need special equipment or treatment?
   - Is the student mature enough for his or her age, or do you need to encourage independence?
   - Does the student fit well in the family and culture or do you need to help build a positive self-concept?

3. To Plan (With the Teacher) Activities That Are Suitable for the Child's Level and Abilities:

COMPETENCY I:

Develop a Special Knowledge of Special Education

OBJECTIVE 4.0

Competency I: Develop a General Knowledge of Special Education

Objective 4.0	Content	Activities	Time	Pre/Post Questions
To explain the Individualized Education Program and its implications for education of handicapped children.	I. The IEP under PL 94-142 A. Definition B. Purposes C. Contents II. Developing the IEP A. The team approach B. The role of the paraprofessional C. Rights of parents and students	Small Group Activity: Participants divide into small groups of 3-5 persons and define the IEP and list the components of the IEP. Large Group Activity: Small groups share their comments with the large group. Mini-Lecture: What Are IEPs. Discuss the definition of the IEP and its components. Handout: Individualized Educational Plan Components. Individual Activity/Handout: Participants are asked to review their program's IEP form and make a list of additional information they would need to complete the IEP. Discussion: Who composed the IEP Team? Trainer and participants discuss who sits on the IEP committee. Discussion should include: • teacher • parents • school administrators • appropriate consultants	10" 10" 10" 5" 5"	Which of the following are not mandated as part of the IEP? a. short-term instructional objectives b. follow-up activities for parents and others to do in the home c. the length of time the IEP covers d. the extent to which the student will be able to participate in regular programs. (b) Parents have the right to attend IEP conferences and to make recommendations concerning educational goals of their child. true/false (true) The child's label is part of the diagnostic information required. true/false (true) Who is responsible for implementing the IEP? a. teacher b. parent c. paraprofessional d. whoever school-based committee designates (a)

Competency I: Develop a General Knowledge of Special Education

Objective 4.0	Content	Activities	Time	Pre/Post Questions
Continued		Handout and Discussion: Role of teacher, aides, parents in the IEP process.	15"	
		Small Group Activity: Participants divide into groups of five. Distribute IEP forms and case study to each team member. Groups develop a sample IEP using handout form.	30"	
		Large Group Activity: Groups share their IEPs.	15"	

MINI-LECTURE

The Individualized Education Program

PL 94-142 requires the development of a written individualized education program (IEP) for each and every handicapped child to be served. The contents of the IEP will be based on the strengths and weaknesses identified in the child's assessment, recommendations made by the teacher, administrator, specialists, parents, and other concerned persons who are or have been involved with the child, and the type of special support services the child may need to benefit from learning experiences.

An IEP is necessary to assure that identified handicapped children receive the types of services and activities which will best help them. Therefore, an IEP helps to guarantee that handicapped children will receive the kind of individual program they need to participate in activities at their own level and to make progress at their own rate.

Working with handicapped children is somewhat like taking a long trip. You need to know the starting point: where the child is now. You need to know what is the destination or goal: what is to be accomplished with the child over a period of time. Finally, you need to have a plan describing how, when, and where the goals are reached with handicapped children which is essential if their special needs are to be met. The IEP is the guide or "road map" in working with the child.

The IEP is the component of PL 94-142 that most affects the classroom teacher. The primary functions of the IEP include the following:

- basis for discussion in program planning
- fosters educational accountability
- is an organizer for the development of the curriculum
- supports movement toward normalization
- enables long-term growth
- allows the involvement of all concerned

As mandated by PL 94-142, each IEP must contain specific components regarding the child's educational needs and the suggested procedures for meeting them. Components which must be present include:

- present levels of educational performance
- annual goals or objectives
- short-term instructional objectives
- the extent the student will be able to participate in the regular programs
- specific educational services to be provided
- projected date for initiation of services

- anticipated duration of services
- evaluation procedures including criteria and schedule for determining whether instructional objectives are being achieved on at least an annual basis

The law also describes the people who should be involved in developing the IEP. These include a representative of the school agency other than the child's teacher (such as the principal), the child's teacher, one or both of the child's parents, the child (where appropriate), other individuals at the discretion of the parent or agency. Stringent measures must be taken to notify the parents of the IEP and their role in developing their child's educational plan. The services of the IEP are legally binding once parental consent has been given to begin implementation of the plan.

In most school districts, a team approach is utilized in developing the IEP. Specialists involved in each phase of the child's education provide long-term goals and short-term objectives for the subject areas (art, PE) or service areas (occupational therapy, music therapy) in which they work with the child. An overall plan is developed with each team member adding to the discussion.

HANDOUT

IEP Component Checklist

Source: Semrau, Barbara. Teaching Every Child: A Guide for Writing Individualized Programs. Jonesboro, Arkansas: FOCUS ON CHILDREN, p. 33.

1. Includes pertinent personal information about child (i.e., name, address, parents, date of birth, health history, medication).	
2. Includes dates of all information entered in IEP.	
3. Specifies date for IEP review and update.	
4. Describes present level of performance in concise, behavioral terms.	
5. Summarizes child's strengths and weaknesses in concise, behavioral terms.	
6. Shows long-term or annual goals, specifying projected dates of achievement.	
7. Shows short-term instructional objectives (behavior, condition, and criteria), which represent the intermediate steps of long-term or annual goals.	
8. Specifies special instructional materials required to achieve goals.	
9. Specifies special equipment required to achieve goals.	
10. Describes the extent to which the child will participate in the regular classroom.	
11. Describes the particular special education or related support services in which the child will participate.	
12. Specifies the person(s) responsible for implementing the individualized educational programs, including signatures on final IEP.	
13. Secures parental participation and/or approval during the preparation of the IEP as evidenced by parent's signature.	
14. Includes results of standardized testing, noting dates tested.	

HANDOUT

The Role of Teachers, Paraprofessionals, and Parents in the IEP Process

TEACHERS	PARAS	IEP COMPONENTS	PARENTS
informal classroom assessment	shares observations with teacher	assessment: present level of functioning learning styles	informal assessment demonstrated at home
work with child in least restrictive setting	assist teacher in working with child	placement: least restrictive settings	agree to placement
set educational goals based upon the wishes of the parents informal assessment and evaluations	NONE	annual goals: instructional objectives	"I want my child to learn to . . ."
TEACH	assist teacher in classroom	implementation and person responsible	volunteer in the classroom, room activities
locate special services, i.e., speech therapist, LD teacher, etc.	NONE	resources needed	discuss concerns and help to locate service providers
did we help child reach the goals set?	assist teacher in evaluating	evaluation	did we help my child to reach the goals set?

Source: Semrau, Barbara. Teaching Every Child: A Guide for Writing Individualized Programs. Jonesboro, Arkansas: FOCUS ON CHILDREN, p. 33.

HANDOUT

Case Study

Louis is a healthy five year old boy. He lives at home with his mother and father. Louis is the only child. Louis is entering a preschool setting for the first time. Louis is anxious to learn to read. He loves to look at story books and retell favorite stories to his parents. He pretends to read as he turns the single pages of the books. He is able to match identical letters but cannot read the letters whether they are lower-cased or capitals. Louis' parents have encouraged his development by supplying him with toys and books and have spent a great deal of time playing and reading with him. Louis' parents think he is pretty independent because he can bathe and dress himself without help. He can wash his face and hands, brush his teeth and put on shirts with or without buttons. He can pull on his pants correctly but is unable to zip his pants without help.

At school, Mrs. Stone (Louis' teacher) asks each student to stand and tell his or her name and age. Louis stands and tells his age, first and last name correctly. When asked his address and phone number, Louis replied that he did not know it. When instructed to draw a picture of his family, Louis completes his drawing happily and describes his mother, father and himself. He draws a human figure with eight parts. His drawing is composed of horizontal and vertical lines and circles. When handed a clean sheet of lined paper and instructed to write his name, Louis grips the pencil very tightly in his right hand and begins writing at the right side of the paper. It is a series of unreadable marks. Louis works independently for five minutes then begins to look around for the teacher and sits idle until she comes to him.

Mrs. Stone asks Louis to write his numbers, gently pointing out that she wants him to start on the left side of the paper. Louis just stares at her. Mrs. Stone points to the left side of the paper and again asks Louis to write his numbers. Louis grips the pencil in his left hand and painstakingly begins marking. It is a series of unreadable marks. Louis works alone for five minutes then sits idle looking for the teacher. Mrs. Stone takes out a number line and asks Louis to read each number as she points to it. Louis tells her that he hasn't learned to read yet, and that his daddy has told him that he would learn to read in school.

In the math learning center, Mrs. Stone presented Louis with four different shapes (circle, square, triangle and rectangle) in sequential order. Louis is only able to name the circle. He tells the teacher he doesn't know the names for the others. When asked to count ten objects, Louis counts five correctly and then begins calling numbers at random.

When presented directional concepts of: big, little, on, under, front, back, in, out, top, bottom, beside and between, Louis was able to identify big-little, on-under and top-bottom. Louis is able to identify the colors, red, blue, and green. He confuses the other colors.

Name:_____

School/Center:_____ City:_____

DOB:_____Chronological Age:_____ Sex:____

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HANDOUT

Individual Education Plan

Child's Name _____ Center _____ School Yr 19__ 19__

DOB _____ Chronological Age ___ Sex: male__ female__

PLANNING COMMITTEE MEMBERS:

_____

_____

_____

_____

_____

Meeting Date(s) _____ IEP Review Date(s) _____

_____ _____

COMMITTEE RECOMENDATIONS

Special Education and/or Support Services

___LD	___Speech/Language
___EMH	___VI
___GT	___HI
___TMH	___Other

Special Instructional Materials/Equipment Required

_____

_____

_____

Describe the extent to which the child will participate in regular classroom:

_____

_____

Functional Assessment

Areas of strength

Areas of concern

Child's Name: _____

Annual Goal(s) _____

_____

_____

Present Level of Functioning	Short Term Objectives	Person(s) Responsible	Beginning and Projected Ending Dates	Review Date	Evaluation Criteria

COMPETENCY II:

Develop a General Knowledge of Seven Handicapping Conditions

OBJECTIVE 1.0

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 1.0	Content	Activities	Time	Pre/Post Questions
To identify the general characteristics, major causes, educational strategies and resources for working with mentally handicapped children.	I. Definition A. Categories B. Characteristics II. Causes III. Teaching Strategies IV. Resources	Brainstorming: Definition and characteristics of EMH, TMH, Severe and Profound. Participants define and offer characteristics for each category.	10"	Worldwide, the leading cause of mental retardation is: a. chromosomal disorders b. infection c. child abuse d. malnutrition (a)
		Mini-Lecture: The Mentally Handicapped Child.	5"	
		Handout and Discussion: Categories of Mental Retardation.	10"	Mildly mentally handicapped children may be diagnosed as developmentally delayed during their preschool years. true/false (true)
		Audiovisual: Videotape or film of a mentally handicapped child.	20"	
		Discussion of Audiovisual	5"	For the majority of mentally handicapped persons, retardation was caused: a. before birth b. at birth c. after birth d. cause cannot be determined (d)
		Handout and Discussion: Causes of mental retardation. Trainer lists headings: Before birth, During birth, and After birth on the chalkboard. Participants name causes of mental retardation.	10"	
		Simulation Activities: Divide participants into small groups and have each group do each exercise.	45"	One resource available to provide information and/or material on the mentally handicapped is:
		Discussion of Simulations	5"	
		Mini-Lecture: General Teaching Strategies.	10"	

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 1.0	Content	Activities	Time	Pre/Post Questions
Continued		Demonstrations: Divide participants into small groups. Trainees will role-play teaching strategies from handout. Groups then share with large group. Handout: Resources for Mentally Handicapped Students.	20" 5"	

MINI-LECTURE

The Mentally Handicapped Child

Mental retardation or mental handicap is a condition that results in a slower than average rate of development. Children who are mentally handicapped have retarded or slow growth in all areas of development.

Mental retardation refers to below average intellectual functioning which occurs along with deficits in adaptive behavior. Adaptive behavior includes skills such as communication, self-care, and social skills. Children who are mentally handicapped will have lags in developing mentally, physically, socially, emotionally, and in self-care and communication skills.

Three categories have been defined with this handicapping condition: mildly retarded or educable mentally handicapped (EMH), moderately retarded or trainable mentally handicapped (TMH), and severely and profoundly retarded. The behavioral characteristics associated with each category are different as are the educational objectives. Also, not all the children identified within each of these categories exhibits all of the characteristics. In addition, sometimes children with other handicaps, i.e., learning disabled, emotionally handicapped, share many of the same characteristics. However, mentally retarded children tend to function at a consistently low level in all areas. Children with other handicaps tend to function more unevenly, with some areas of difficulty and some areas of much higher ability.

Although estimates of the number of mentally handicapped individuals vary according to sources used, most authorities agree that between two and three percent of all people in the U.S. are mentally handicapped to some degree. This means that approximately 1.1 to 1.65 million school aged children are mentally handicapped and that for every 1,000 school aged children, 25 will be mildly mentally handicapped, four will be moderately mentally handicapped and one will be severely or profoundly handicapped.

HANDOUT

Categories of Mental Retardation

Category	Another Name	IQ	
Mildly Retarded	Educable Mentally Handicapped (EMH)	50-75	Frequently not diagnosed in preschool years; if it is diagnosed it is diagnosed and is called developmentally delayed. Development may seem slow or the child may show some delay in learning to talk and have other developmental problems. Able to learn social, communication and academic skills but at a slower rate than "normal." Can care for themselves.
	(Semi-independent)		
Moderately Retarded	Trainable Mentally Handicapped	35-50	Frequently identified at birth or during preschool years. Development proceeds at 1/2-3/4 the rate of "normal" children. Need special training in preschool in such areas as toilet training, eating, motor development, and social skills. As adults, trained to work in sheltered workshops and some jobs in the community. Need moderate supervision all their lives.
	(Semi-dependent)		
Severely and Profoundly Retarded		0-35	Identified at birth. Often have physical handicaps. Motor development is usually very, very slow. Need 24 hour supervision. Need very structured programs—can learn some self-help skills and some speech.
	(Dependent)		

CAUSES OF MENTAL RETARDATION

It is difficult to discuss the causes of mental retardation accurately, because less than six percent of the cases of mental retardation have known causes, while 94 percent are unknown. Of the largest group of mentally retarded people, the mildly retarded, about 80 percent have unknown causes. The majority of the mildly retarded are cultural-familial, which implies that the conditions stem from an interaction of both environmental and hereditary factors.

There are at least 200 different conditions that can cause mental retardation. Many of these conditions are named with lengthy medical terms. Some of them are presented here in hopes that an awareness of these conditions will somehow help in the prevention of mental retardation. Causes of mental retardation are so numerous and varied that it is difficult to categorize them adequately. Damage which results in mental retardation can occur before (prenatal), during (perinatal), or after birth (postnatal).

Before Birth

This time is also called the "prenatal" period. It covers the period from conception to birth.

Damage to the unborn baby can result in the improper development of or injury to the child's brain. Prenatal causes of mental retardation can include:

1. Infections and diseases:

   a. Toxoplasmosis—This is a condition caused from eating infected raw meat or from being around the feces of cats that have eaten such meat.

   b. Syphilis—The bacterium of congenital syphilis can damage the egg or sperm before conception occurs. The fetus can also be damaged if the mother contracts syphilis during the pregnancy. In most cases, the central nervous system of the fetus is damaged, resulting in mental retardation.

   c. Radiation—There is danger to the fetus if the mother receives x-rays (particularly in the middle area of the body) during pregnancy. There is also evidence that x-rays received in the months prior to pregnancy by either the mother or father can cause damage.

d. Encephalitis—This is a form of brain inflammation. Occasionally, it develops after an attack of high fever brought on by some other illness such as measles, chicken pox, whooping cough, pneumonia, or meningitis.

e. Rubella (German Measles)--Although this is a mild disease in children, it can be dangerous for the fetus of the pregnant woman. Rubella contracted during the first three months of pregnancy can result in mental retardation, deafness, eye defects, or other disabilities. Rubella can be controlled by use of routine immunization. Because the vaccine contains a live rubella virus, it is not safe for women during pregnancy or even shortly before conception.

f. Cytomegalo virus--This viral infection can cause damage or death to the fetus. In some cases the mother may not even be aware that she has an infection.

g. Rh Disease—This is a blood problem in which antibodies from the mother's blood destroy red blood cells in the infant and cause a build-up of poisons that destroy brain cells. This blood incompatibility results from the mother having an Rh- factor in her blood and the infant having an Rh+ factor (inherited from the father) in its blood. Giving the baby all new blood by transfusion before or after birth can overcome this problem. An Rh vaccine can now be given to the Rh- mother after the first Rh+ baby is born, to prevent the problem in future pregnancies.

2. Drugs: Any drug can cause injury to a fetus and should be taken by a pregnant woman only under a doctor's care (including aspirin and cold medications).

3. Accidents: Any fall or accident that involves the mother can damage the fetus.

4. Chromosomal disorders: Chromosomes are rod-shaped structures in each cell that carry all the information that determines inherited characteristics such as color of eyes, type of hair, sex, mental capacity, etc. The normal cell contains 46 chromosomes. During conception these chromosomes and their heredity information are transferred to the embryo (beginning baby). An extra, damaged, or missing chromosome will result in a chromosomal disorder.

Down's Syndrome is the most common chromosomal disorder resulting in mental retardation.

5. Malnutrition: Poor diet in the mother can deprive an unborn infant of substances essential to proper development. The central nervous system's greatest development occurs before birth and during the first year after birth. Protein deficiency during this time can damage a child's mental capacity.

6. Alcohol: Research shows that alcoholic mothers are more likely to have mentally retarded children than non-alcoholic mothers. Whether this is due to the malnourished condition of the mother or to the alcohol itself is not clearly understood.

During Birth

1. Premature Birth: Children weighing less than 5 lbs. 8 ozs. (2,500 grams) at birth are considered premature. Because all of the systems in the body are usually not fully developed until the nine months of pregnancy are completed, there is a higher risk in "premees" than in full-term babies for physical or mental problems.

2. Birth Injury: When labor is too quick, it can cause bleeding inside the baby's head. When labor is too long, it can result in a lack of oxygen to the baby's brain (anoxia). If the umbilical cord separates or collapses before the baby breathes on his/her own, it results in a lack of oxygen tc the baby's brain. Excess anesthesia during delivery can slow down the baby's breathing.

3. Drug-Related Withdrawal Symptoms: This can occur in babies born of drug addicted or alcoholic mothers. If not treated immediately, the baby can experience tremors, hyperactivity, vomiting, fever, convulsions and coma.

After Birth

1. Malnutrition: Malnutrition is considered to be the leading worldwide cause of mental retardation. As the child's brain grows, it requires certain essential substances to insure proper development. A diet lacking in these substances will result in mental retardation.

2. Accidents: Any serious injury to the skull can cause brain damage and/or mental retardation.

3. Anoxia: Near drowning, choking, suffocation, and carbon monoxide poisoning deprive the brain of oxygen. This deprivation can cause mental retardation.

4. Child Abuse: An abused child is one who is purposely physically or mentally injured or neglected by a parent figure. Injuries inflicted by the parent may result in brain damage or even death for the child. At least 10,000 children a year are abused and one out of four dies of his/her injuries. These injuries can also cause mental retardation.

5. Poisoning: Lead poisoning can result in brain damage. It is usually caused from children chewing on objects painted with lead-based paints or inhalation of battery fumes. Carbon monoxide poisoning is another possible danger.

6. Metabolic Disorders: Many of the following diseases actually start before birth but are not observed or do not develop until after birth.

   a. Phenylketonuria (PKU)--This is a disorder in which an infant is unable to properly metabolize protein. This causes a build-up of a chemical in the blood and results in damage to the brain. A blood test is given 72 hours after the birth of a baby (after the baby has received milk) to check for this substance. Some medical facilities also give a urine test at a postnatal check-up to further establish the presence or absence of the substance.

   b. Cerebral Palsy--This is characterized by a disorganization of motor control which results from damage to the central nervous system. It can occur before, during, or after birth. More than half of cerebral palsied children have mental retardation.

   c. Hypoglycemia--This disorder causes low blood sugar which deprives the brain of food. Steroid drugs and a special diet are used for treatment.

   d. Hypothyroidism--This disorder can result in mental retardation because of defective thyroid function. Proper thyroid function is necessary for adequate brain cell metabolism.

   e. Hydrocephaly--This is an unusually large head often caused by too much fluid retained in the brain. Damage results from excess pressure in the brain which destroys cells.

   f. Microcephaly--This means undersized skull. It may be caused by premature closing of the bones of the skull either before or soon after birth (also called craniostenosis) or by lack of growth of the brain.

   g. Galactosemia--This is an inability by the body to properly metabolize milk sugar. Newborn infants can be tested and put on a special diet for this disorder.

7. Environmental Deprivation: This is a condition in which the people and events that surround a child have failed to meet his/her basic physical, emotional and social needs. The child's surroundings have failed to stimulate his/her thinking and thus ability to grow and learn and discover become damaged.

8. Convulsive Disorders: Convulsive disorders (seizures) can cause brain damage if the seizures are severe and uncontrollable with medication.

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[1]Reprinted with permission from Mental Retardation. Anchorage, Alaska: Easter Seal Society for Alaska Crippled Children and Adults, 1977, pp. 33-37.

SIMULATION ACTIVITIES

1. For five minutes, write sentences using only words of two syllables.

2. Difficulties with tactile discrimination. With a thick sock on each hand, put on a flannel shirt and button the buttons; tie the laces on a pair of sneakers. With a thick sock on each hand, put your hands in a bag of common household or classroom objects and try to identify some of them by touch.

3. Difficulties with visual discrimination. With a layer of surgical gauze taped over your eyes with masking tape (like goggles), try to read a book; try to drop clothespins into a bottle. With gauze over the eyes and socks on each hand, do a simple puzzle.

4. Tie a cord between the ankles. Keep the cord taut. Tie a cord around the upper torso and arms, so that the arms are forced to stay touching the sides of the body from the elbows up. Now--walk slowly down the corridor and back; sit on the floor and play.

Source: Bookbinder, Susan. Mainstreaming: What Every Child Needs to Know About Disabilities. Providence: The Rhode Island Easter Seal Society, 1978, p. 80.

HANDOUT

General Teaching Strategies

It is important to help mentally retarded children gain skills that advance them to the limit of their potential. Most teaching strategies/techniques are applicable to mentally retarded children as they are to the non-retarded. However, the effectiveness of a particular strategy relies heavily on the teacher's ability to use it as well as his personal feelings toward it.

Multi-Sensory Approach

Multi-sensory approach refers to teaching children through the use of all of their senses:

1. visual—information gained from seeing
2. auditory—information gained from hearing
3. tactile—information gained from touching or feeling
4. olfactory—information gained from smelling
5. gustatory—information gained from tasting
6. kinesthetic—information gained from movement and the position of muscles within the body

Information is received by the senses and is sent to the brain where it is processed and made meaningful. Using as many of the sensory channels as possible in teaching a concept or task helps a child learn.

It is difficult for mentally retarded children to learn; therefore it is especially important to use the multi-sensory approach with these children because it helps to get them totally involved in a learning situation. Since mentally retarded children do not learn well simply by having things told or read to them, it is important to use a very concrete way of teaching—the multi-sensory approach.

Examples of teaching activities using the multi-sensory approach are:

1. Teach body parts by playing a game in which the children rub damp wash cloths on their arms, legs, faces, chest, and tummies as they sing a body parts song, "This is the way we wash our arms, etc." The children feel the wet wash cloths on the body parts as they hear the word for the part and see the part they rub.

2. Teach about an orange by having the child feel and smell one, look at its color, say "orange," then cut it open, squeeze it and drink the juice.

3. Teach a letter of the alphabet by saying "This is a 'G'," while the child looks at it. Then have the child trace around a sandpaper "G" with the fingers or a crayon while saying its sound.

4. Use a picture or chart to help a child visualize a story or a set of instructions. If the child only hears the story or instructions, the information might be meaningless. Using "visuals" to describe the actions you are talking about helps the child learn.

5. Model an activity (go through an activity yourself with the child watching as you describe what you are doing). Modeling uses the child's senses of hearing and vision. "Watch me stack these blocks."

6. Give physical assistance to the child and actually move him/her through an activity to help the muscles get the feel of what needs to happen. Teach a child to take off a coat by physically moving him/her through each step in the process and talking about what (s)he is doing. "Your coat is unzipped, let's move your hand and arm out of the sleeve," etc.

Step-By-Step Learning

Step-by-step learning or "task analysis" is an important technique when teaching mentally retarded children.

Most skills are more complicated than at first realized. They require breaking down into short, simplified, sequential steps so a child can learn one step at a time and feel success. A child who is learning "step-by-step" needs plenty of time to repeat a step until it is mastered before moving on to the next step.

Two possible ways of using step-by-step learning are techniques called frontward chaining and backward chaining. In frontward chaining you teach the first step in a series of steps first. In backward chaining you teach the last step of the desired behavior first.

Frontward Chaining . . .

Begin by teaching the first step of the desired behavior. As each additional step is taught, it is added to those that the child can do until the entire series is complete. For Example: If you want the child to build a tower of five blocks, the first step would be to put one block on a table. The second step would be to stack two blocks. The third step would be to stack one more block and so on until all five blocks were stacked.

Backward Chaining . . .

Begin by teaching the last step of the desired behavior first. Then have the child complete the last two steps of the task and continue until the entire series is complete from the last to the first step. The child is praised for the finished task and experiences the feeling of accomplishment as (s)he does more and more of the task independently. Some activities, especially self-help skills, lend themselves to the backward chaining approach. For Example: If you want to teach a child to put on a pair of pants:

Step 1. Start with the pants on almost up to the child's waist. Have the child help pull them to the waist. Praise the child by saying, "good putting on pants."

Step 2. Start with pants on the child's legs, near the ankles. Have the child pull them up independently. Praise the child by saying, "very good . . . that's nice work."

Step 3. Hold out one pants leg and teach the child to put his/her feet into the pants one foot at a time. Then have the child pull up the pants. Praise the child by saying, "I like the way you put on your pants."

Step 4. Teach the child to put in both feet independently and pull up the pants. Praise the child by saying, "good putting on your pants."

Step 5. Hand the child the pants in the proper position and have the child put them on independently. Praise the child by saying, "good job."

Step 6. Teach the child the front and back of the pants as well as the top and bottom, and have the child put them on independently. Praise the child by saying, "good putting on your pants."

Step 7. Give the child the folded pants and have the child lay them out and put them on correctly. Praise the child by saying, "I'm proud of the way you put on your pants."

This process of breaking down tasks is necessary for whatever task you teach special children.

Success-Assured Activities

It is important to plan activities in which the mentally retarded child can experience success. Failure breeds failure and results in a fear of trying

new things. Success helps develop confidence and a desire to learn more.

The following are some techniques that will help assure success:

1. Step-By-Step Learning--Breaking down tasks into small achievable steps provides the child many opportunity for success.

2. Physical Assistance--Guiding or moving the child through an activity until (s)he can do it alone helps assure success. It is better to guide the child through to the correct responses (this is called "errorless learning") than to waste time on trial and error techniques.

3. Teaching at the Appropriate Level--There are three teaching levels to be aware of:

   a. a tolerance level at which the child works easily using skills already learned (independent level).
   b. a challenge level at which it is slightly difficult for the child to do the task (instructional level).
   c. a frustration level at which it is too difficult to even try the task.

   Everyone learns best at the first two levels. Children enjoy activities they can do well, but they feel overwhelmed and defeated with things that are constantly frustrating to them.

4. Avoiding Drastic Changes in Activities--Mentally retarded children frequently have difficulty moving from one activity to another. A teacher needs to help the child gradually adjust to a new situation. Tell the child what activity is coming next and help make the transition smoothly. For example: If the child is playing a quiet game alone, (s)he shouldn't be asked to quickly join a noisy, active game with a large group of children. Include the child in an activity with a small group first, then later move him/her into the larger group.

5. Repetition--Children with learning difficulties often have short attention spans. They don't learn well in activities that require concentrating for long periods of time. They learn best when activities are short and repeated many times. Often their memory spans are short, so it is important to repeat the same activity in the same sequence of steps each day until it becomes automatic.

6. Practice--Once children have mastered a particular skill, they need to "try out" their new skill at different times, in different settings, and with different materials. A child might learn how

to tie tennis shoes but be lost when asked to tie brown leather shoes. Learning to tie different kinds of shoes is the kind of practice the child will need.

7. Behavior Modification--When a child is rewarded or reinforced with something positive when (s)he behaves appropriately and is ignored when (s)he behaves inappropriately, the process is called behavior modification. A behavior that is followed by a meaningful reward is likely to be repeated. A behavior that is not rewarded is not likely to be repeated. Praise is usually a very meaningful reward if given immediately after a correct behavior. Some children need what is called a concrete reinforcement like cereal bits or color chips that they can trade in for play time. Let the children show and tell what rewards they prefer. Praise should always be given along with concrete reinforcement so that later the praise can be substituted for the concrete reward. As a child begins to learn new behavior, rewards should still be given but with less frequency than when the child first started.

Structure in the Classroom

Structure is provided when a routine is followed, or when activities are planned so that children will know what to expect next. Mentally retarded children do not learn by just absorbing what is going on around them. They might be content to sit on the fringe and watch. They need to be directly involved in a specific, structured learning activity in which they are required to respond by moving or talking. Often instruction on a one-to-one basis is necessary.

The following techniques will help provide structure for mentally retarded children:

1. Remove distractors--Make sure the child is not bombarded with too many materials and toys at once. Arrange teaching settings so that they are not cluttered or confusing. Remove materials the child does not need to pay attention to, and limit material available to that which the child can handle without becoming distracted. Many mentally retarded children are easily distracted by too many things going on around them. They cannot filter out the important details from all the things they hear and see.

2. Divide areas--A mentally retarded child will react best to places that are divided into activity areas--a nap area, an art corner, a quiet reading area. Different areas give clues about the types of stimuli the child can expect and about the items on which the child needs to focus.

3. Limit numbers--Mentally retarded children often work best in small groups in which a lot of individual attention can be given. In addition, children are usually less distracting to each other in small groups than they are in large groups.

4. Maintain attention--When teaching any activity be sure to hold the child's attention. Say, "Look at me," and maintain frequent tactual and visual contact with the child. If a child is not paying attention, nothing can be learned from an activity.

Behavior Management

Behavior management (or discipline) is extremely important for the mentally retarded. More adult retardates lose jobs because of their lack of social skills (getting along with others) than for any other reason. The following techniques have helped children learn these needed skills:

1. Use praise and positive reinforcement for desired behavior and ignore unwanted behavior, if possible.

2. Teach the child to listen, to take turns, to stay with the class, to eat appropriately, to use the bathroom correctly, and to control impulses.

3. Remember to treat each child and situation individually since no "rules of thumb" work for all children.

4. Be consistent. Decide what limits are necessary and stick to them.

5. If a child becomes too excited or uncontrollable in a group, isolate the child for a short time. Moving a child to another part of the room is one way of achieving isolation. Frequently the child will decide when (s)he is ready to join the group again. Long periods of isolation are ineffective.

6. Never use physical pain, insults, or fear as management techniques.

7. Don't threaten. A child's memory is short and threats will soon be forgotten.

8. Don't punish by putting the child to bed--this may cause the child to think of normal bedtime as punishment.

9. Don't punish by saying, "I won't love you." The child will respond much better if (s)he knows (s)he is loved.

10. Friendly firmness rather than punishment is basic for discipline.

11. Give a warning when changing activities such as, "In five minutes we will stop painting."

12. Be sure the child understands what is expected. Telling usually isn't enough. The child must be shown. "Let me show you where to put these messy paint brushes."

13. Tell the child what to do rather than what not to do. Say, "put your cup on the table" rather than "don't throw your cup on the floor."

14. Act as if you expect the child to cooperate and (s)he usually will.

15. Give one direction at a time and keep it simple.

A child who is being stubborn or uncooperative may be hungry, tired, ill, uncomfortable, or having an emotionally difficult time.

Be aware of the child's mental age and capabilities. Expecting too much from a child can result in frustration, anger, and unhappiness for the child and the teacher. Expecting too little can result in boredom and lack of educational stimulation for the child.

Reprinted with permission from Mental Retardation. Anchorage, Alaska: Easter Seal Society for Alaska Crippled Children and Adults, 1977, pp. 97-98, 101-102, 104-105, 108, 110-111.

HANDOUT

Resources for Mentally Handicapped Students

LOCAL/STATE

1. Local public health nurse, school nurse
2. Developmental Evaluation Center
3. March of Dimes
4. Association for Retarded Citizens
5. Mental Health Clinic
6. Sheltered Workshop

NATIONAL ORGANIZATIONS

1. National Association for Retarded Citizens
   2709 Avenue E East
   P.O. Box 6109
   Arlington, TX 76011

2. National Foundations--March of Dimes
   Public Education Department
   P.O. Box 2000
   White Plains, NY 10602

3. The Council for Exceptional Children
   1920 Association Drive
   Reston, VA 22091

4. National Institute of Mental Health
   5600 Fishers Lane
   Rockville, MD 20852

COMPETENCY II:

Develop a General Knowledge of Seven Handicapping Conditions

OBJECTIVE 2.0

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 2.0	Content	Activities	Time	Pre/Post Questions
To identify the general characteristics, major causes, educational strategies, and resources for working with hearing impaired children.	I. Characteristics II. Causes III. Teaching Strategies IV. Resources	Mini-Lecture: The Hearing Impaired Child.	10"	Moderate hearing loss (41-55) may require special seating arrangements and special education services but will not usually require hearing aids. true/false (true)
		Brainstorming and Handout: Characteristics of Hearing Impaired Students. Participants suggest characteristics of the hearing impaired student. Trainer records them on chalkboard; then uses handout to reinforce the activity.	10"	A person born with normal hearing whose hearing has become non-functional through accident or illness is called: a. congenitally deaf b. adventitiously deaf c. hard of hearing d. functionally deaf (b)
		Audiovisual: Videotape, film of a hearing impaired child.	15"	
		Discussion of Audiovisual	5"	
		Handout: Causes of Hearing Loss.	10"	Which of the following is not a usually identified cause of deafness? a. toxoplasmosis b. German measles contracted by mother during pregnancy c. Rh incompatability d. family history of deafness (a)
		Mini-Lecture: General Teaching Strategies for Hearing Impaired Students.	10"	
		Demonstration: Basic signs should include fingerspelling, common signs—yes, no, bathroom, sit, eat, drink, etc.—and some "fun" signs—names of people in the group.	20"	
		Simulation Activity: Wearing ear plugs, or cotton, trainees should be given a spelling test.	10"	One resource available to provide information and/or materials on the hearing impaired is: 77

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 2.0	Content	Activities	Time	Pre/Post Questions
Continued		Discussion of Simulation Activity.	5"	
		Demonstration: Hearing Aids.	5"	
		Handout: Resources for Hearing Impaired Students.	5"	

MINI-LECTURE

The Hearing Impaired Child

Persons described as "hearing impaired" may have difficulty in hearing in one or both ears or they may not hear at all; the hearing loss may be severe or profound. Hearing impaired individuals who are able to understand human speech, either with or without the assistance of a hearing aid may also be referred to as "hearing impaired." A person who cannot understand human speech even with a hearing aid and whose hearing is non-functional for the usual purposes of life is considered "deaf." The term "congenitally deaf" refers to deafness at the time of birth. Deafness which is acquired after birth is called "adventitious deafness."

The degree of hearing loss experienced by a hearing-impaired individual is based on the sensitivity to sound, measured in decibels. A decibel (dB) is a unit measuring the intensity or loudness of a sound. A very quiet conversation registers 20 decibels, normal conversation is 60 decibels, and a riviting machine at 30 feet measures 100 decibels. In describing hearing impairment, the higher the decibel loss, the more severe the impairment. Mild or slight hearing loss (27-40 decibels) may require special seating in the classroom. A student with moderate hearing loss (41-55 decibels) may require special seating arrangements as well as hearing aids and/or other special educational services.

A child with moderately severe hearing loss (56-70 decibels) will require individual hearing aids and will require special assistance in vocabulary and speech development. A more severe hearing loss (71-90 decibels) usually classifies the student as deaf, although he may be able to hear loud sounds at a close distance; intensive special education services will be required. Profound hearing loss (91 decibels or more) requires special educational programming and speech and language may not develop without intensive instruction.

There are several ways to differentiate types of hearing loss.

Conductive loss occurs when sound waves are not conducted to the inner ear due to problems in the middle or outer ear. Hearing impairment caused by problems with the inner ear is called sensorineural loss. In this instance, sound is properly conducted, but is not converted into a message which can be passed on to the brain. Mixed losses refer to hearing impairments which involve both conductive and sensorineural losses.

Estimates are that there are between 275,000 and 385,000 hearing impaired children between the ages of five and eighteen (Gearheart, p. 122), or that approximately 0.5 to 0.7 percent of the school aged population have some degree of hearing loss.

HANDOUT

Characteristics of Hearing Impaired Students

The amount of hearing loss is not the only factor which will influence behavior and achievement in the hearing impaired child. Another factor which must be taken into consideration when planning educational programs is the age at which the hearing loss occurred. Whether the onset of the impairment took place before or after the development of language will be important in determining the type and extent of special education services necessary. This factor will also influence the extent to which the student will be able to comprehend written language and master oral speech. Other factors such as previous remedial instruction and general intelligence will also need to be considered.

Some characteristics which might be observed in a child with a hearing impairment are (Gearheart, pp. 123-124):

- lack of attention
- turning or cocking the head
- difficulty in following directions
- acting out, stubborn, shy or withdrawn behavior
- reluctance to participate in oral activities
- dependence on classmates for instructions
- best achievement in small groups
- speech defects
- disparity between expected and actual achievement
- medical indications

The possibility of hearing impairment should also be considered when a child one year or older does not imitate sounds and simple words; responds primarily to loud sounds and voices; often asks "huh?" or "what?"; draws away from the group or plays alone; seems resentful or annoyed, and avoids people; or seems restless and strained and shows exhaustion and fatigue early in the day.

HANDOUT

Causes of Hearing Loss

I. Conductive Hearing Loss

A. Outer Ear

1. The outer ear may be malformed during the prenatal development of the baby. When this occurs, sounds cannot be funneled to the middle ear.

2. Ear wax may accumulate in the ear canal and block it.

3. Infections of the skin that lines the auditory canal can cause the skin to swell, thereby closing up the canal.

4. Tumors may develop in the ear canal.

These outer ear disorders obstruct the conduction of sound to the middle and inner ear and produce a conductive type of hearing loss. The middle ear and inner ear mechanisms are perfectly good, but the sound waves are not being channeled to them because something is blocking the ear canal.

B. Middle Ear

1. As with the outer ear, the middle ear may be malformed during the prenatal development of the baby.

2. The eustachian tube may be blocked by adenoid tissue, tumors, or any swelling of the tissue about the tubal opening in the nose. When this occurs, air cannot get into the middle ear space.

3. Otitis media, an infection of the middle ear occurs when bacteria travels through the Eustachian tube and into the middle ear. This infection produces an inflammation of the ear drum and an accumulation of pus within the middle ear space. If the infection is left untreated, the pressure of the pus on the eardrum causes the drum to break.

4. Otosclerosis is another disorder of the middle ear. A common cause of conductive hearing loss in people between the ages of 15 and 50, it is hereditary in nature. New bone tissue is produced in the region of the oval window, and constricts the stirrup so it does not vibrate at the oval

window. This disorder produces a conductive type of hearing loss; the inner ear mechanism is good, but sounds are not getting to it.

II. Sensori-Neural Hearing Loss

A. Inner Ear

1. Hearing loss that occurs before the child is born is known as a congenital loss and may be due to:

   a. German measles (Rubella) contracted by the mother during the first three months of pregnancy.
   b. viral infections occurring in the mother during pregnancy.
   c. inherited deafness because of genetic make-up.

2. Hearing loss that occurs during the birth process may be due to:

   a. Rh incompatibility.
   b. problems of prematurity.
   c. prolonged lack of oxygen (anoxia).

3. Hearing loss that occurs after birth may be due to:

   a. infections accompanied by high fever.
   b. mumps.
   c. degeneration of the auditory nerve due to hardening of the arteries.
   d. certain drugs used in large quantities such as aspirin and aspirin-like compounds (quinine, streptomycin, and neomycin).
   e. repeated loud noises. The ear mechanism is made to tolerate only a certain level of noise. A greater level of noise, especially if it continues for a long time, will cause a sensori-neural hearing loss. Such a loss is likely to be permanent. It is the kind of loss that permits an individual to hear speech, but not understand it; speech is blurred or distorted. Such a loss makes hearing speech in a noisy environment difficult and may be accompanied by a ringing in the ears that further interferes with understanding of speech.

Source: Special Needs of the Young Exceptional Child: Hearing Disabilities, Anchorage, Alaska: Easter Seal Society for Alaska Crippled Children and Adults, 1977, pp. 34-36.

MINI-LECTURE

General Teaching Techniques for Hearing Impaired Students

The number one rule in working with hearing impaired students is to talk to them at every possible opportunity. Children normally learn to use words after they have heard the sounds in those words used over and over again. Students with hearing difficulties often have to learn by watching (lip reading) and using a proper hearing aid. This process of learning takes much longer than learning by sound alone. Children with hearing impairments need every chance they can to see speech. Even though you know the child you are working with cannot hear what you are saying, talk to him/her.

Get down to the child's eye level. Lipreading is difficult. Having the speaker's lips on the same level as the child's eyes makes the task a little easier.

Come close to the child when you talk. If the child has any residual hearing, she/he needs to be close to the sound if she/he is to hear it. Also, it is difficult to lipread from a distance.

Speak naturally. Use your normal voice at a moderate rate of speed. Exaggerating your words or speaking more slowly than usually confuses the child.

Speak in short and simple but whole sentences. Do not use baby talk. If the child is exposed only to incomplete sentences, that is all the child will learn. The goal is to teach the child normal language.

Face the light when speaking to a child with a hearing problem. If the light is behind the speaker's back, the child will have trouble lipreading.

Seat the child near the front of the classroom where she/he can read your lips and follow classroom activities more easily. If she/he does not wear a hearing aid the better ear should be toward the teacher and the rest of the class. If she/he wears a behind-the-ear aid, the ear with the aid should be toward the teacher and the class. The child should sit on the window side of the room so that she/he is not facing the sunlight while attempting to lipread the teacher or classmates.

Give visual cues to what you are saying. Touch the object you are talking about. Let your face show what you are feeling. Manual communication (sign language and fingerspelling) provides very special clues used by deaf children, their families, and friends. Manual communication is not difficult to learn and can do much to help a deaf child grow normally in all areas.

Use music and rhythm activities in order to increase auditory stimulation. Let the children feel the sounds of a drum or piano. Encourage hearing impaired children to play instruments and join in rhythm games. Rhythm can be seen and felt, as well as heard.

Seat the hearing impaired child close to you in group activities so she/he can lipread better, hear the sounds she/he is capable of detecting, and get visual cues to what is happening.

Learn the proper care and use of the hearing aid if a child you are working with wears one.

Be aware of some side effects in children with hearing losses. The inability to communicate can be very frustrating. Sometimes hearing impaired children develop emotional and behavioral difficulties because of their frustration.

Repeat directions and comments when you doubt if they are understood.

Give hearing impaired children lots of praise when they listen well. It takes more energy for them to listen. Praise them for talking, too.

Ask them lots of questions to make sure the hearing impaired child understands directions and/or stories. Questions requiring answers other than "yes" or "no" help you check the child's comprehension.

Give the child lots of opportunities to talk. Some things that encourage talking are toy telephones, puppets, walkie-talkies, tape recorders, and animals.

COMPETENCY II:

Develop a General Knowledge of Seven Handicapping Conditions

OBJECTIVE 3.0

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 3.0	Content	Activities	Time	Pre/Post Questions
To identify the general characteristics, causes, educational strategies, and resources for working with the speech and language impaired child.	I. Characteristics A. Speech Problems B. Receptive Language Problems II. Causes III. Teaching Strategies IV. Resources	Mini-Lecture: The Speech and Language Impaired Child. Small Group Activity: Participants divide into small groups and list characteristics of speech and language impaired children. Groups share their lists, trainer adds others. Handout: Speech and Language Impairments. Trainer uses handout to discuss types of speech and language problems. Small Group Activity and Role-Play: Participants divide into dyads and use the handout—Role Play Situations to Stimulate Speech and Language. Each group identifies the kind of speech and language problems in each of the six situations. Then they select one situation and role-play in front of the large group. Mini-Lecture: Causes of Speech and Language Problems. Audiovisual: Film or videotape on speech and language impaired child in the classroom.	10" 10" 10" 15" 5" 15"	Early identification and treatment of speech and language disorders may also reduce behavior problems. true/false (true) Echolalia is primarily a problem of: a. hearing loss b. receptive language c. expressive language d. speech difficulty (c) Loud play and screaming may result in a husky and hoarse voice. true/false (true) One resource available to provide information and/or materials on the speech and language impaired is: _____

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 3.0	Content	Activities	Time	Pre/Post Questions
Continued		Mini-Lecture: Teaching Strategies.	5"	
		Handout: Specific Teaching Tips.	5"	
		Simulation Activity: Divide trainees into groups of three persons. The group will complete a problem while simulating a speech difficulty.	15"	
		Discussion of Simulation Activity.	5"	
		Handout: Resources for Speech and Language Impaired.	5"	

MINI-LECTURE

The Speech and Language Impaired Child

Language is the tool by which we learn new ideas, store information, share thoughts with others, and solve problems. Hardly an hour goes by that we do not use some form of language. Most children develop language and speech skills informally with no special help or attention. As adults we take for granted the ability to listen, understand, think, and talk.

Some children, however, do not learn to talk automatically and need special help in developing language and speech skills. Some children cannot receive or hear what is said because of ear problems. Think about the last time your ears were stopped up from a bad cold; think about watching television with the sound turned off. You see a person's mouth moving and know something is happening, but you do not hear the words. Some children are able to hear, but do not understand what is said. This is like being in a foreign country and having others speak to you in a language you do not understand. From facial expressions and gestures, you know that you are expected to answer. Although you "hear," you do not understand the words and find yourself cut off from many things.

Other children have difficulty in using words. They may receive information or hear, and they may understand what is said, but they cannot express themselves clearly. Words and sounds are jumbled, and although the child may want to communicate with others, he or she cannot speak well enough to be understood.

Estimates are that 2-3 percent or 1,650,000-2,200,000 of all school-aged children have some type of speech or language impairment. In the case of some 5, 6, and 7 year olds, speech or language difficulties may be temporary or very minor; other students will require intensive special education services to overcome their disabilities.

The sooner children with language and speech disabilities receive help, the better their chances for developing normal speech and language. Early identification and treatment of language and speech disorders also reduces behavior problems which may develop when a child is frustrated about the inability to communicate.

HANDOUT

Speech and Language Impairments

Definition: A child exhibiting the following identifiable disorders shall be reported as speech impaired.

- receptive and/or expressive language impairment
- stuttering
- chronic voice disorders
- serious articulation problems (affecting social, emotional and/or educational achievements
- speech and language disorders accompanying hearing loss: cleft palate, cerebral palsy, multiple handicapping conditions and other sensory and health impairments. This does not include conditions which accompany early childhood development as a part of the normal development process.

Language Disorders (includes problems in both understanding and using spoken language).

Receptive language impairment--results in a difficulty understanding spoken language.
Expressive language impairment--difficulty using language (speaking).

Speech Disorders (includes stuttering, voice disorders and articulation disorders).

Stuttering--speech impairment involving a disorder in the rhythm or flow of speech cuh-cuh can I guh -go now?).
Voice disorders--involves loudness, pitch or quality of the voice; hypernasal--sound produced through the nose; denasal--sounds as though child has cold or sinus condition.
Articulation disorders--involves a problem with the production of speech sounds. Sounds may be left out (omissions) or distorted, or extra sounds may be added, or sounds may be substituted.

Disorders associated with Cleft Palate (narrow opening in the roof of mouth)--children with repaired and unrepaired cleft palates may experience difficulty pronouncing s, z, sh, ch, k, and g sounds.

Disorders associated with hearing loss--child's voice may be too loud or too soft, may use single words or phrases. Grammar and sentences may not be as developed as other children of the same age.

General Characteristics

- difficulty putting words together to form phrases or sentences
- labored speech
- does not imitate sounds and simple words
- responds primarily to loud sounds or voices
- frequently is inattentive and lacks interest in conversations
- fails to answer when called upon
- gets confused about directions or doesn't understand them at all
- makes frequent mistakes in carrying out requests and answering questions
- often asks, "what?" or "huh?"
- shows a confused expression when directions or questions are being given to the class
- turns one side of his/her head toward sounds, indicating hearing loss in one ear
- displays poor speech, substitutions, omissions, poor voice quality
- draws away from the group, plays alone, seems resentful or annoyed, avoids people

HANDOUT

Role-Play Situations to Stimulate Speech and Language

1. Suzy-Q is in the housekeeping area stirring in a pot with a spoon. The Teacher goes over to Suzy-Q and asks: "what are you stirring Suzy-Q?" Suzy-Q smiles and says: "cake." The Teacher says: "Suzy-Q is stirring a cake!"

2. As the teacher plugs the record player into the wall outlet, she says to the children around her: "I'm plugging the record player into the wall because it's music time!"

3. John says: "me gotta use bathroom." The teacher says: "Johnny say: 'I need to use the bathroom." Johnny says: "I need to use the bathroom."

4. Robert lives alone with his mother. His mother omits many sounds which require the use of the tongue and teeth together. Robert imitates the speech he hears at home.

5. Anita goes over to the teacher and says: "dress!"

6. Rachel, who is seven years old, says: "I fall down" or "my dog run away." She frequently confuses the past and present tense.

MINI-LECTURE

Causes of Speech and Language Problems

1. Developmental delay or mental retardation. Some children take longer to learn to talk than others because of low intelligence. Usually the child who is developmentally delayed shows difficulties in all areas of growth including communication, socialization, cognition, motor, and self-help skills.

2. Brain Damage

3. Hearing Loss—a child must hear speech before he/she can learn to talk.

4. Lack of Stimulation—children who live in a quiet, non-verbal environment are often delayed in learning to talk.

5. Structural Deviation—a child must have workable physical equipment in order to learn to talk.

6. Unknown causes—it is often impossible to determine the causes of speech and language problems.

Source: Funk, Linda. Special Needs of the Young Exceptional Child: Language Disabilities. Anchorage, Alaska: Easter Seal Society for Crippled Children and Adults, 1977, pp. 34-35.

MINI-LECTURE

Teaching Strategies for the Speech and Language Impaired

Once a child has been identified as having a speech and/or language problem, there are many things which can be done to promote speech and language development. In order to help children learn to understand, learn to talk, and learn to act appropriately in a school program, it is necessary to use appropriate speech and language as models for the students, and to plan and present specific activities.

When planning activities for speech and language impaired children, keep in mind that it is important for them to learn words that are useful, and that will help them get along a little better in the world. This means that they need to learn the names of actions and objects in everyday use. They need to learn words like "potty," "water," "eat," and "chair," before they learn "radio," "dive," and "fly." Encourage the children's efforts to talk even if the meaning is not clear or if it is not said very well. Repeat words correctly but do not try to make children say them correctly. Don't use baby talk. Remember, you are a model for children, and they will imitate you.

Also remember that it is easier to teach concrete and observable actions and objectives, like "eat," "drink," "push," "dog," "milk," "water," than abstract notions such as "pretty," "helpful," "larger," etc. It also helps the children learn if you use the other senses, especially the senses of sight and movement.

Children with speech and language problems may also have coordination problems, or problems understanding what touches them. They may not like physical contact unless they expect it or start it themselves. Don't be offended by this. These children may not understand what they are feeling and may find touch uncomfortable.

All children and especially children with speech and language problems may become upset at unexpected situations. They need structure, routing, and consistency; they need to know when to expect meals and playtime; they need to know where they should sit and what the daily routing will include. Limit choices and distractions. Children with speech and language problems are often confused when they try to pay attention to two things at once, or when they have to decide between too many choices.

It is important that children with speech and language impairments feel good about themselves. They should be helped to find what they can do well: color, kick a ball, clean the erasers, pass out juice, etc., and should be given many chances to do these things. Brag about them, give them

praise, and help them learn how to find things they can do and like to do without forcing them to practice and drill on things that they are unable to accomplish.

HANDOUT

Specific Teaching Tips

1. Consider the difficulty of the words before teaching: concrete and observable actions and objects like "eat," "drink," "push," "dog," "milk," "water," are easier to learn than abstract notions like "pretty," "helpful," "larger."

2. Be sure to use objects, pictures, gestures, or other visual clues with all instructions you give to a child. Repeat your instructions and rephrase them if they are not understood.

3. Teach for understanding first. Don't try to make children talk or repeat until they understand. This will make children not want to talk when they might not have much to say in the first place.

4. Try to have the child look at you when you are talking. Many children with speech and language problems cannot pay attention to two things at the same time.

5. Use lots of repetition: tell them, show them, let them practice, and tell them again.

6. Listen to and watch their responses to see whether they understand what you are saying.

7. Remember to encourage any attempts made by a child to talk even if the meaning is not clear or if it is not said very well.

8. Use correct sounds and words: do not use baby talk, incomplete sentences, etc.

9. Use everyday occurrences to teach words: when serving snacks teach things like, "Hold out your hand," "Eat it," "Juice," "Milk," "Give everybody a cup."

10. Use your own physical activities and body movements and those of the children to teach: body parts (back, leg, nose, hand); body actions (sit-ups, turn around, jump, run, walk); movements of toys which children can manipulate (roll it, push it, pull it, catch it).

11. Remember to avoid unexpected situations. A surprise, even a happy surprise such as a birthday party or a trip to the circus, can be very upsetting.

12. Limit the number of decisions the child must make. For example, give the child a choice of only two things to do rather than saying, "What do you want to do now?" Having to make too many decisions may confuse or frustrate the child.

13. If the child has tantrums or becomes very upset, take the child to a quiet place and stay with the child while he or she calms down. Spanking or using harsh words may confuse the child and upset the child even more.

SIMULATION ACTIVITY

Trainees are divided into groups of three and each assumes one of the following roles:

1. speech and language impaired student
2. receiver
3. observer

The person who is the student places a marshmallow under his/her tongue and reads the following to the teacher:

"SPEEDING PIPERS PRICKED A PECK OF LITTLE PEPPERS;
A PECK OF PRICKLY PEPPERS SPEEDING PIPERS PRICKED;
IF SPEEDING PIPERS PICKED THE PECK OF PRICKLED PEPPERS;
HOW MANY FICKLED HELPERS DID THE SPEEDING PIPERS PICK?"

The receiver records what the student is saying and repeats it back to her. The observer records what is happening in the group.

The simulation activity should be followed with a discussion of the exercise.

HANDOUT

Resources for Speech and Language Impaired Children

National

1. American Speech and Hearing Association
   9030 Old Georgetown Road
   Washington, DC 20014

2. National Association for Hearing and Speech Action
   814 Thayer Avenue
   Silver Spring, MD 20910

3. The Alexander Graham Bell Association for the Deaf
   3417 Volta Place, NW
   Washington, DC 20007

4. Council for Exceptional Children
   1920 Association Drive
   Reston, VA 22091

State and County

1. State Department of Public Instruction
   Division of Exceptional Children
   Raleigh, North Carolina

2. Speech and Hearing Center
   University of North Carolina at Greensboro
   Greensboro, North Carolina

3. Guilford County Mental Health Clinic
   300 N Edgeworth Street
   Greensboro, North Carolina

4. Developmental Evaluation Clinic
   2311 W Cone Boulevard
   Greensboro, North Carolina

COMPETENCY II:

Develop a General Knowledge of Seven Handicapping Conditions

OBJECTIVE 4.0

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 4.0	Content	Activities	Time	Pre/Post Questions
To identify characteristics, causes and teaching strategies for working with orthopedic and health impaired children.	I. Introduction A. Definitions B. Prevalence II. Specific conditions A. Orthopedic and neurologic impairments B. Other health impairments III. Resources	Film: Different Approaches or other films which focus on abilities caused by orthopedic and health impairments. Mini-Lecture: The Orthopedically or Health Impaired Student. Handout: The Orthopedically or Health Impaired Student. Activity Session: Trainees will simulate various handicapping conditions. Mini-Lecture: Mechanical Aids and Special Equipment. Demonstration: Common mobility and safety aids: • canes • braces • artificial limbs • prone standers • bolsters • floor chairs • non-slip placemats • plates with raised edges • training cups • helmets	30" 5" 5" 20" 5" 20"	Children with "other health impairments" have been described as students with limited strength, vitality or alertness due to chronic or acute health problems. true/false (true) The largest number of physically disabled children needing education services falls in the category of: a. spina bifida b. muscular dystrophy c. cerebral palsy d. juvenile rheumatoid arthritis (c) Orthopedic impairments are caused by diseases. true/false (false) Since children with physical handicaps often need to sit, stand, walk and use their hands, it is important to help them manage their social skills before

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 4.0	Content	Activities	Time	Pre/Post Questions
Continued		Handout: Educational Implications of Orthopedic and Health Impairments.	10"	encouraging them to strengthen the other developmental skills. true/false (true)
		Brainstorm Resources: Handout: Resources.	5"	When using a wheelchair, the student should be reminded to: a. sit on the seat belts when not using them b. lock the chair before getting in or out of it c. put foot rest up when not in use d. wear seat belt when going down a ramp unassisted (b)
				One resource available to provide information and/or materials on orthopedic and health impairments is: _____

MINI-LECTURE

The Orthopedically or Health Impaired Child

(Major Resource: Gearheart, Bill R. Special Education for the 1980's. C. V. Mosby Co., St. Louis, 1980.)

According to PL 94-142, the term "orthopedically impaired" refers to a condition which "adversely affects a child's educational performance. The term includes impairments caused by congenital anomolies ('club foot,' absence of some member), impairments caused by disease (polomyelitis, bone tuberculosis), and impairments from other causes such as cerebral palsy, amputations, and fractures or burns which cause contractures." Children with "other health impairments" have been described as students with limited strength, vitality or alertness due to chronic or acute health problems such as a heart condition, hemophelia, epilepsy, lead poisoning, lukemia or diabetes, which adversely affects the child's educational performance. General estimates are that 0.5 percent, or 275,000, school-aged children are orthopedically or other health impaired. Children with a variety of orthopedic and health impairments may be encountered in special education settings. Some will do best when placed in self-contained classrooms where they can receive the specialized educational services which maximize their learning potentials; others will be able to attend regular classes all or part of the day.

HANDOUT

The Orthopedically or Health Impaired Student

CEREBRAL PALSY--students with cerebral palsy make up the largest number of physically disabled children needing special education services. This disability is the result of damage of or mal-development of the brain before, during or after birth. It is characterized by varying degrees of impairment of muscle coordination and the ability to perform normal motor patterns and skills. Many children with cerebral palsy have other handicapping problems such as hearing, visual, perceptual, learning, and intellectual function. Types of cerebral palsy include:

- spasticity--increased muscle tone; overactive, tight muscles
- athetosis--uncontrolled, jerky and irregular movements
- ataxia--lack of coordination related to balance
- mixed--various combinations of the other types

The types of involvement caused by cerebral palsy are as follows:

- hemiparesis--muscles on one side of the body are affected
- diplegia--lower limbs are primarily involved with some effect on muscles in arms and hands
- triplegia--one upper and two lower limbs are involved
- quadraplegic--all four limbs are equally affected

SPINA BIFIDA--(cleft spine) usually identified at birth, is caused by a birth defect in which there is damage to the spinal cord nerve roots. A child with spina bifida has an open backbone (spine) that did not close during development in the womb. The opening allows nerve tissue in the spinal column to slip through a form a sac that sticks out of the body.

MUSCULAR DYSTROPHY--there is only one common fatal childhood form, Duchenne. It is characterized by an increasing weakness of the skeletal muscles. Early symptoms include difficulty in running or climbing stairs. Later the child will be confined to a wheelchair. Shoulder and arm weakness appear in the later stages.

JUVENILE RHEUMATOID ARTHRITIS--it is characterized by stiffness of the joints and usually develops between ages two and five. Some children get relief from symptoms after a period of 10 years.

EPILEPSY--is a seizure disorder caused by excessive electrical discharges released in some nerve cells of the brain. When this happens, the brain cannot function peroperly for a short time and loses control over muscles, consciousness, senses and thoughts. The loss of functions is only temporary. Common types of seizures are:

- grand mal--most severe form; person loses consciousness, has uncontrolled movement of the body

- petit mal--short in duration (5-20 seconds); behavioral changes are slight--short lapse of attention.

JUVENILE DIABETES MELLITUS--a metabolic disorder caused by the body's inability to burn sugar and starches. Classroom personnel need to be aware of signs of too much or too little insulin. Too much insulin signs include headache, nausea, vomiting, shallow breathing and/or cold, moist skin; treatment is to give orange juice, candy, or sugar cube. Too little insulin signs include fatigue, drinking large amounts of water, frequent need to urinate, excessive hunger, excessive breathing and/or warm, dry skin; treatment is to give insulin.

HEMOPHELIA--blood disorder that is genetically based occurring primarily in boys. It is characterized by excessive bleeding, externally and internally due to cuts, scratches, bumps, etc.

SICKLE CELL ANEMIA--a hereditary blood disorder more prevalent among but not limited to the black population. Hemoglobin in the red blood cells is distorted into a sickle shape which does not pass through blood vessels. The lack of blood supply to tissues causes severe pains, swelling of joints, fatigue, and high fever. Potential damage to tissues may occur causing degeneration of joints and related orthopedic problems.

CYSTIC FIBROSIS--a terminal hereditary disorder found primarily in the Caucasian population. It is characterized by chronic lung disease and pancreatic deficiency. Major problems are dry cough, bronchial obstruction by normal secretions, and susceptibility to infections. Affected persons may have a life expectancy into young adulthood.

GENERAL CHARACTERISTICS

- child may tire easily or appears weak and listless
- excessive hunger
- excessive thirst
- frequent need to urinate
- period of daydreaming
- excessive coughing and wheezing
- dry coughs
- limited movement
- uncontrollable bleeding from small cuts or bruises
- repetition of questions which have been answered, or repetition of movements such as buttoning and unbuttoning shirt or sweater (psycho-motor seizure)

SMALL AND LARGE GROUP ACTIVITY

Simulation of Various Health and Orthopedic Impairments

Participants divide into small groups. Each group is secretly assigned an orthopedic or health impairment to act out in the large group. The small groups are given 5-10 minutes to put their role-play and dialogue together. Then they act out their impairment using all group members. The large group guesses the impairment being acted out and identifies the features or characteristics that helped them to identify the impairment.

(Allow 10-15 minutes for each group to share, more time may be needed if group is large.)

MINI-LECTURE

Mechanical Aids and Special Equipment

Being able to sit, stand, walk and use one's hands to explore the world are the basic skills on which every child's social, emotional and cognitive development are based. Since children with physical handicaps often need to sit, stand, walk and use their hands, it is important to help them manage these social skills before encouraging them to strengthen the other development skills.

In many instances, it is best to allow handicapped children to learn an activity without special aids or mechanical assistance. However, when they end up having to pay more attention to balance or position than the learning activity itself, mechanical assistance should be used. The needs of each handicapped youngster vary widely depending on the child's special condition and how severely it affects physical ability. The child's mechanical assistance requirements, as well as how assistance is used, will also vary widely.

There are many types of adaptive equipment used by physically handicapped children. Physical and occupational therapists are the specialists who will be able to guide and assist in the best selection and use of equipment or special positioning for each child.

DEMONSTRATION

Demonstrate Common Mobility and Safety Aids

Trainer obtains the following mobility and safety aids (or picture of them) and discusses the use and purpose of each. Information on each piece of equipment can be taken from "Trainers Guide on Mobility Aids." The aids are:

- crutches
- canes
- braces
- artificial limbs
- prone standers
- bolsters
- floor chairs
- non-slip placemats
- plates with raised edges
- training cups for drinking
- helmets
- forearm crutches
- wheelchair

TRAINERS GUIDE ON MOBILITY AIDS

CANES--children who can walk but need a little support often use one or two canes. Canes should have rubber grip tips on the ends to keep them from sliding on the floor. Proper lengths of the cane is important. Children can usually walk best when their elbows are 35 degrees from being straight when they stand holding the canes.

CRUTCHES--crutches are used when the child needs more support. If crutches are too long, they may damage the nerves in the child's arms. You should be able to slide three fingers between the top of the crutch and the child's underarm when he is standing degrees with the crutches in front of and out to the side of the feet. The child's elbow should have a 35 degree angle.

The child should carry his weight on the hands not the underarms. Do not let the child hang on the tops of crutches. Doing this can also damage arm nerves.

FOREARM CRUTCH--the forearm crutch is another type of crutch. The forearm crutch contains a mental cuff which fits below the elbow. The elbow is bent to 35 degrees. The hand rests on the support bar.

WALKERS--walkers are used when a child needs maximum support to balance in walking.

The walker should always be ahead of the child. The child's elbows should be bent 35 degrees. When going over a door jam or onto carpet, the front end of the walker should be lifted up to prevent falling.

WHEECHAIRS--there are a wide variety of wheelchairs and wheelchair attachments to meet the individual needs of each child.

The wheelchair must fit the child correctly and have the attachments that are designed for the child's specific disabilities, in order to be totally and easily functional. <u>One wheelchair cannot meet the needs of all children.</u>

Wheelchairs that fit correctly contain the following:

- seat belts that are used at all times
- foot rests that allow the child's heels to rest on them with the knee bent at least 90 degrees
- a seat depth that allows the child's knees to bend 90 degrees and does not hit the back of the knees
- a seat width that is not so wide that the child cannot reach the wheels with both hands

Wheelchair safety points: (Trainer may wish to write these on chart paper and attach to wheelchair and discuss them during demonstration)

- lock the chair before the child gets in or out of it
- if child cannot propel the wheelchair alone, lock the chair at all times when the child is unattended
- require child to wear seat belt at all times
- when going down a hill or ramp, turn the chair around and back down to prevent dumping the child out by accident
- when going up a step, turn the chair around backward, tip the chair way back and pull up the step on the back wheels; when going down to the step, face the chair frontwards, tip the chair way back and go down the step on the back wheels
- always seek help if you are not sure you can handle it safely yourself

SCOOTER BOARD--some children are not ready for canes, crutches, walkers, or wheelchairs but would benefit by a means of safe mobility in the home or classroom. Other children, although they have mobility by other means, still benefit from prone progression as a means of strengthening their head, arm, and trunk control. For these children scooter boards are appropriate and fun.

The length and width of the scooter board will depend on the child's individual disability and needs. They can be constructed out of plywood or pressed wood, padded with foam and covered with vinyl fabric. Four ball bearings (not wheel) casters are screwed in each corner. A tie may be placed around the child's trunk for security if necessary.

HELMETS--children who fall frequently, who cannot reach out with their hands to break their fall, who cannot hold their head up to avoid hitting it, or who have seizures which result in falls often need to wear helmets to prevent serious injury during physical activity.

Helmets can be homemade out of fabric and foam, or can be a football helmet, or be specifically designed for handicapped children.

The child's feelings about wearing a helmet and the kind of falls will determine what kind of helmet he needs.

SAFETY RESTRAINERS--a variety of harnesses exist to assist children who lack head or trunk control when sitting in their wheelchairs. A physical or occupational therapist should assist you with their selection and use.

BRACES--are mechanical devices made of metal bars and leather cuffs and straps. They are designed to:

- prevent deformities
- to correctly position a part of the body
- to prevent further injury
- to provide support and limit motion at weak joints

Braces do not improve a child's muscle function but support and position the limb for better use of the existing muscle function.

Some braces only control the ankle joint and are called short leg braces. Long leg braces are braces which control the ankle and the knee. Long leg braces with a pelvic (hip) band control the ankle, knee and hip.

Braces must fit correctly. This means the joint where the brace bends at the hip, knee, and ankle should be at the same level as where the child's hip, knee and ankle bend. The cuffs and straps should not be so tight or so loose that the child develops pressure sores or is pinched by them when standing.

ARTIFICIAL LIMBS--artificial limbs or prosthesis are worn by all children who are missing an arm or leg, hand or foot from a birth defect or injury. They are substitutes for the most part and enable the child to function more normally.

Children who have artificial limbs are often seen by an occupational therapist if they are missing an arm or hand, and a physical therapist if they are missing a leg or foot.

Children who have recently received an artificial limb will need to gradually increase the lengths of time they wear it to prevent the skin from developing blisters. Once the skin has toughened, it is important that the child wear and use the artificial limb all day (unless otherwise directed) in order to learn to use it effectively and to accept the device as part of the body.

Children will experience some discomfort as they learn to use an artificial limb. If it is excessive or if they develop a blister on their stump, be sure to inform the doctor or therapist. The artificial limb should not be worn as long as a sore exists on the stump.

POSTURE AIDS--because of abnormal muscle tone, handicapped children will often need special help positioning to improve their motor function and to prevent deformity. What they are positioned on and how they are positioned is determined by their disability and individual needs. A physical or occupational therapist will be able to advise you if and how a child needs special positioning.

Positioning aids include:

- wedges
- bolsters
- wheelchairs
- floor chairs
- prone standers

Wedges and bolsters help children develop head and trunk control while freeing their arms and hands for play.

Floor chairs help children to sit erect on the floor with legs extended straight in front. It assists with sitting balance while helping to keep the back and leg muscles from getting tight. A floor tray can be placed in front of the child for feeding or table activities.

Prone standers are used to provide support in standing when the child is unable to stand otherwise. It encourages the development of good joint structure and alignment, normal function of the digestive and eliminative systems, and helps keep bones and muscles strong. It also encourages the development of good joint structure and alignment.

FEEDING AIDS—children who have difficulties controlling their arms and hands will benefit from the use of special bowls, cups, glasses and spoons. There are a variety of utensils available.

Plates with raised edges help children who have difficulty scooping food on a spoon.

Non-slip placemats can be used under dishes when the child's lack of motor control frequently results in the plates sliding off the table.

Spoons with lowered bowls or rotated bowls help the child who has difficulty scooping or getting the spoon in his mouth. Plastic coated spoons are also more comfortable for the child who frequently bangs the spoon in his mouth, teeth or gums while eating.

Training cups with two handles and a spout give children better control over drinking. If a child has difficulty picking up the cup, he can lean over to drink from a stationary glass with a lid and plastic straw.

The best assistance to children with feeding difficulties is a table and chair at the proper height. Feet should touch the floor or support surface. Arm rests should be provided if necessary, for balance. The tray or table top should be at elbow height.

HANDOUT

Educational Implications of Orthopedic and Health Impairments

Cerebral Palsy

If placed in proper educational program, the curriculum may not differ significantly from peers. Often there will be adapted or modified equipment and materials. Examples of such modifications are: pencil holders made of clay, adapted typewriter, page turners, stand-up tables, weight placed on the hands or wrists and paper holders.

Muscular Dystrophy

During early stages very few modifications and adaptions will be necessary. Physical activities are encouraged, but with periods of rest as needed. Eventually the child will not be able to be served in a school setting and will have to receive homebound instruction.

Spina Bifida

Teachers will need to work closely with medical personnel to ensure proper health care. Some children with spina bifida can benefit from regular education with only minor modifications and adaptations.

Spinal Cord Injury

Psychological supportive personnel may be necessary. For more involved injuries, adaptive aids may be required.

Juvenile Rheumatoid Arthritis

Children will need freedom to move around and should not sit for long periods of time. If hands are affected, alternative methods for classwork may need to be utilized, i.e., tape recorder.

Epilepsy

Present few classroom problems. Teachers should be aware of medication taken by the child and should report any seizure to medical personnel.

Juvenile Diabetes Mellitus
(body's inability to burn sugars and starches)

Classroom personnel need to be aware of signs of too much or too little insulin. Too much insulin signs include headache, nausea, vomiting, shallow breathing and/or cold, moist skin; treatment is to give orange juice, candy, or sugar cube. Too little insulin signs include fatigue, drinking large amounts of water, frequent need to urinate, excessive hunger, excessive breathing and/or warm, dry skin; treatment is to give insulin.

Cancer

Child may need to rest and learn to deal with the potential terminal nature of his illness.

Cardiac Condition

Few modifications may need to be made. Most will be concerned with physician's directions regarding physical activity.

Hemophilia
(excessive bleeding)

Absences from school which will disrupt child's education. Helping the youngster develop responsibility for protecting himself will be the educational concerns.

Sickle Cell Anemia

Frequent absences may affect academic performance.

Cystic Fibrosis
(chronic lung disease and pancreatic deficiency)

Academic learning should not be affected. Strenuous physical activity may need to be limited. Psychological implications will be an important factor.

LARGE GROUP BRAINSTORM

Resources Available Which Provide Information and/or Materials on Orthopedic and Health Impairments

Trainers instruct group to brainstorm services which provide information and/or materials on orthopedic and health impairments.

RESOURCES AVAILABLE WHICH PROVIDE INFORMATION AND/OR MATERIALS ON ORTHOPEDIC AND HEALTH IMPAIRMENTS

Allergy Foundation of America
801 Second Avenue
New York, NY 10017

American Cancer Society
219 East 42nd Street
New York, NY 10017

Arthritis Foundation
1212 Avenue of the Americas
New York, NY 10036

Epilepsy Foundation of America
1828 L Street, NW
Washington, DC 20036

The Council on Exceptional Children
Division for Children with Orthopedic and Health Impairments
1920 Association Drive
Reston, VA 22091

Muscular Dystrophy Association of America, Inc.
810 Seventh Avenue
New York, NY 10019

United Cerebral Palsy Association, Inc.
66 East 34th Street
New York, NY 10016

National Easter Seal Society
2023 West Odgen Avenue
Chicago, IL 60612

COMPETENCY II:

Develop a General Knowledge of Seven Handicapping Conditions

OBJECTIVE 5.0

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 5.0	Content	Activities	Time	Pre/Post Questions
To identify characteristics, causes, teaching strategies, and resources for working with emotionally handicapped children.	I. Introduction A. Definitions B. Prevalence II. Characteristics III. Causes IV. Teaching Strategies V. Resources	Mini-Lecture: The Emotionally Handicapped Child. Handout: General Characteristics of Emotionally Handicapped Children. Mini-Lecture: Causes of Emotional Handicaps. Brainstorm: Specific behavior one might see which are under the general characteristics listed on handout. Handout: Characteristics of Emotionally Handicapped which appear in Various State Guidelines for Placement of Emotionally Handicapped Students. Examples of common behaviors of emotionally handicapped students. Mini-Lecture: Teaching Strategies for Emotionally Handicapped Students. Handout: Teaching Strategies to Use with Emotionally Handicapped Students.	5" 5" 5" 5" 5" 5" 5"	The term "emotionally handicapped" is used to describe: a. persons who become upset easily b. persons who have difficulty coping with their environment c. persons who can't learn because of emotional problems d. persons who exhibit a great deal of emotions (b) Emotionally handicapped individuals are known by their: a. constant complaining b. outward exhibition of anger c. behavior excesses and deficiencies d. attempts to gain attention (c) Everyone becomes emotionally disturbed at one time or another. true/false (true) One warning signal that can alert one to the fact that an

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 5.0	Content	Activities	Time	Pre/Post Questions
Continued				emotional or social handicap may exist is: a. the child who constantly develops illnesses, pains or unexplanable fears b. the child who is absent a lot c. the child who has only 2-3 friends d. the child who constantly seeks attention (a) Social and emotional handicaps are the result of dysfunction of the central nervous system. true/false (false) The behavioral theory attributes the cause of emotional handicaps to: a. learning inappropriate behavior(s) b. neurochemical irregularities c. problems which occur between the individual and various social systems during interactions d. unconscious conflicts (a)

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 5.0	Content	Activities	Time	Pre/Post Questions
Continued				When working with emotionally handicapped individuals in a school setting, it is best to have an unpredictable schedule of activities. This prevents boredom and loss of interest: true/false (false) The emotionally handicapped student should not be kept abreast of his/her progress because this only causes more frustration. true/false (false) One resource available to provide information and/or materials on emotional handicaps is: _____

MINI-LECTURE

The Emotionally Handicapped Child

(Major Source: Gearheart, Bill R. Special Education for the '80's. C. V. Mosby Company, St. Louis, 1980.)

Several terms are used interchangeably to refer to children with emotional problems. Commonly heard terminology includes behavior disordered, psychologically disordered, emotionally handicapped, emotionally disturbed and socially handicapped. For the remainder of this presentation we will use the term "emotionally handicapped" to describe those children who have difficulty coping with their environment.

While there are a variety of definitions which have been put forth to describe the emotionally handicapped child, consensus has not been reached in the educational or mental health communities. This, coupled with the lack of acceptable standardized tools to assess mentally handicapping conditions makes diagnosis difficult. Because of the lack of standardized definitions and diagnosis, it is difficult to estimate the number of school aged children who are emotionally handicapped. Estimates range from .05 to 81.5 percent of the school population, but realistically it would appear that about 2-3 percent or 1,100,000-1,560,000 children between the ages of 5-18 are emotionally handicapped to an extent which requires special educational services. Most children considered to be emotionally handicapped will, with treatment, lead normal lives.

It is important for us to remember that children with emotional problems are known by their behavior excesses and deficiencies. For example, an emotionally handicapped child may show excessive anti-social behavior (such as kicking and hitting), or he may show a deficiency in social-interpersonal behavior (such as being extremely withdrawn).

HANDOUT

Characteristics of Emotionally Handicapped Children

There are numerous definitions of emotional handicaps and various listings of characteristics. However, Bower (1969) listed characteristics of emotionally handicapped children in terms of their visibility to the classroom teacher. According to Bower, there are five basic warning signals that can alert one to the fact that some social and emotional handicap may exist. They are:

1. The child who can't seem to learn in school:

   Some children have difficulty learning in school even though their intelligence and physical development seem normal. Some have difficulty because their social and emotional troubles prevent them from being able to gain from learning experiences. Others are undiagnosed learning disabled children who are struggling under years of frustration and misunderstanding. The emotional problems in these learning disabled are not the cause of their learning problems, but rather emotional difficulties have resulted from continued failure and frustration.

2. The child who is unable to form or maintain satisfactory interpersonal relationships with peers, teachers, and others:

   Maintaining satisfactory relationships requires more than just getting along. It focuses on the ability to build warm and sympathetic bonds. It implies enjoyment in working and playing constructively with others and by oneself. However, the child who is emotionally handicapped may, by his/her very actions, repel others and eliminate any chance for a good relationship to grow.

3. The child who acts inappropriately to normal directions and situations:

   If the teacher hands back an incorrect paper to be done over, reactions may vary considerably among several children. The aggressive child may refuse to follow routine, directions, or rules unless (s)he chooses to do so. The withdrawn child may seem to conform to directions until (s)he can escape through physical hiding (under a table) or into fantasy through daydreaming. The child who has no self-confidence may see everything as a threat and tend to follow a programmed set of behaviors whether appropriate or not. The "con-artist" may appear to agree to demands but behind the teacher's back may be doing exactly what (s)he wants to do.

4. The child who generally feels unhappy or depressed:

Depression and unhappiness are typical of children who express feelings of discontent all the time. Nothing or nobody can satisfy or please them. These children seldom smile. They seem to enjoy wallowing in their misery.

5. The child who constantly develops illnesses, pains, or unexplained fears:

The tendency to develop illness and fears is especially apt to be found in withdrawn children and/or children who lack self-confidence. It provides them with a socially acceptable excuse to get out of situations that are threatening to them.

LARGE GROUP BRAINSTORM

Specific behaviors one might see which fall under one of the general characteristics of an emotionally handicapped child.

EXAMPLE: Suzy Q's IQ scores reflect normal intelligence when tested; however, Suzy Q's constant disruption of classroom activities by jumping on the surface of desks, throwing pencils at the teacher and attempts to climb out of classroom windows, require that Suzy Q remain outside of the classroom until she regains control. As a result, Suzy Q has fallen behind in her studies and is regressing academically to a lower level. This could be an example of the child who can't seem to learn in school.

MINI-LECTURE

Causes of Emotional Handicaps

A variety of theories have been offered to explain why emotional handicaps occur. These include biophysical, psychodynamic, behavioral, sociologic and ecologic theories. To get an idea of how these theories explain emotions let's look at each theory briefly.

BEHAVIORAL THEORY—is based on the assumption that children learn their patterns of behavior and have therefore learned inappropriate behaviors.

PSYCHOANALYTIC THEORY—is based on the assumption that behavior disorders are the result of unconscious conflicts or problems that the child is experiencing.

BIOPHYSICAL OR CIOLOGICAL THEORY—is based on assumptions that behavior disorders are the result of dysfunction of the central nervous system due to brain lesions, neurochemical irregularities or genetic defects.

SOCIOLOGICAL AND ECOLOGICAL THEORY (basically the same)—are based on the assumption that behavior disorders are the result of flows or problems which occur during interactions between the child and his environment (school, church, community, etc.).

Although numerous theories have been put forth to explain why emotional handicaps occur, there is not one cause for social or emotional handicaps in a child.

LARGE GROUP BRAINSTORM

Home or school situations or conditions which may lead to emotional handicaps.

Trainer instructs participants to brainstorm home or school factors which may lead to emotional handicaps. To start the group, you might ask if insensitivity to a child's individuality (by demanding uniformity) could lead to emotional problems? If group has not warmed up, list "inappropriate expectations" (too high or too low); you may need to elaborate on this point to get participants to thinking.

HANDOUT

Characteristics of Emotional Handicaps Which Appear In Various State Guidelines for Placement of EH Students

Keeping in mind that children who are emotionally handicapped may exhibit one or several of the characteristics below, the following, rather lengthy listing, attempts to itemize characteristics appearing in various state guidelines for placement of children in programs for the emotionally handicapped: (Gearheart, p. 293)

- avoids contact with others
- avoids eye contact
- behavior that is ritualistic
- chronically disobedient
- covert or overt hostility
- disorganized in routine tasks or spatial orientation
- displays temper tantrums
- disturbances of sleep or eating habits
- emotional isolation
- exaggerated or bizarre mannerisms
- few or no friends
- frequent and/or persistent verbalizations about suicide
- frequent illness
- frequent unexplained crying
- frustration level is low
- hyperactivity
- inability to complete tasks
- inappropriate verbalizations and noises
- inattentive
- inconsistent in academic performance
- inconsistent in friendships
- lethargic
- out of touch with reality
- physically withdraws from touch
- physically aggressive to others or property
- rapid and severe changes of moods
- refuses responsibility for actions
- requires constant reassurance
- repetitive behavior
- seeks attention
- self-mutilating
- self-stimulating
- severe reactions to change in usual schedule
- sexual deviations
- truant
- unexplainable "accidents"

- unexplained academic decline
- unmotivated
- unreasonable and/or unexplained fears
- verbally aggressive
- verbally disruptive

HANDOUT

Common Behaviors of Emotionally Handicapped Students

CASE #1:

Edwin in impulsive. He acts first and thinks later. Edwin is in constant motion and rarely finishes what he starts. He has difficulty focusing on one thing without being easily distracted by sound or movement.

CASE #2:

Carolyn is a "con artist." She pretends to be polite and friendly. She pretends to be "nice" to cover up her "not so nice" intentions. Carolyn plays one parent against another to get what she wants. Carolyn is clever at playing the school against her home to cover unaccepted behavior.

CASE #3:

George attacks other children physically. He has uncontrolled temper tantrums. He threatens, scolds, lies. George gets other children to attack physically. He intentionally breaks toys belonging to others.

CASE #4:

Susan complains daily about not "feeling well" when given individual or group tasks to do in the classroom. When asked what is bothering her she says "I just don't feel good and I don't see why I have to be bothered with that stuff." Susan has had numerous check-ups by physicians, and they have not been able to identify a problem. Susan's mother says "Susan is just plain lazy," and ignores her. Susan's teacher says "Susan just doesn't want to do her work."

Cases 1-3 taken from: Social and Emotional Disabilities, Special Needs of the Young Excpetional Child. Mayer, Collen & Funk, Linda. Easter Seal Society of Alaska Crippled Children and Adults, 725 E Street, Anchorage, Alaska.

MINI-LECTURE

Teaching Strategies

Children with emotional handicaps in school settings usually benefit when there is some consistency between techniques used in the home and the school. Teachers will need to be aware of any medication being taken by the student, and will want to cooperate with a student's psychiatrist to whatever extent possible. Positive reinforcement in a structured environment has often been effective in helping emotionally handicapped students reach their potential. In the next activity we will review some practical teaching strategies which have been suggested for use in the classroom.

HANDOUT

Teaching Strategies to Use with EH Students

(Major Source: Haring, N. G. and Phillips, E. L. Analysis and Modification of Classroom Behavior. Englewood Cliffs, New Jersey: Prentice Hall, 1972.)

Several practical teaching strategies have been suggested by Haring and Phillips (1972) for use in the classroom:

1. Get the child down to work immediately upon entrance into the activity area, thereby precluding a period of excitement, "horseplay," or daydreaming.

2. Have a schedule sheet or notebook for each child in which the actual activities and the times devoted to each are indicated.

3. Let every child know that he/she has a schedule to work from daily.

4. Expect the child to offer protest now and then, but be prepared to meet objectives.

5. Be equally ready to offer support and reward for activities successfully done.

6. Never "attack" the child as a person; center corrections on actual tasks or specific behaviors.

7. Evaluate the child often enough to keep fully abreast of his/her progress.

8. Assume that the child's knowledge of his/her progress must come from you and standard and formal evaluations of his/her progress for his/her own self-knowledge.

9. Realize that as the child progresses, she/he will also grow in the emotional areas because she/he is operating as an integrated unit.

10. Think of emotional as a by-product of successful functioning; improve emotional responses by setting up tasks in clear, firm, consistent wyas so that success is likely because it is based on realistic goals.

LARGE GROUP BRAINSTORM

Resources available which provide information and/or materials on emotional handicaps.

Trainer instructs participants to brainstorm resources which provide information and/or materials on emotional handicaps.

HANDOUT

Resources for Information and Materials on Emotional Handicaps

1. League for Emotionally Disturbed Children
   171 Madison Avenue
   New York, NY 10017

2. National Society for Autistic Children
   169 Tampa Avenue
   Albany, NY 12208

3. Mental Health Materials Center
   419 Park Avenue, South
   New York, NY 10016

4. National Association for Mental Health
   1800 North Kent Street
   Arlington, VA 22209

5. The Council on Exceptional Children
   Division for Children with Emotional Handicaps
   1920 Association Drive
   Reston, VA 22091

COMPETENCY II:

Develop a General Knowledge of Seven Handicapping Conditions

OBJECTIVE 6.0

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 6.0	Content	Activities	Time	Pre/Post Questions
To identify the characteristics, causes, teaching strategies and resources for working with the learning disabled child.	I. Introduction A. Definition B. Prevalence II. Characteristics III. Causes IV. Teaching Strategies V. Resources	Mini-Lecture: The Learning Disabled Child. Handout: Causes and Characteristics. Simulation of Activities which can be used with LD students. Mini-Lecture: Teaching Strategies. Handout: Teaching Strategies. Brainstorm: Resources. Handout: Resources.	5" 10" 20" 5" 5" 5" 5"	Children with learning disabilities experience: a. difficulty in learning which can be traced to a specific handicapping condition such as visual or hearing impairments or emotional handicaps b. a disorder in one or more of the psychological processes involved in using or understanding language, spoken, or written c. unusually high success with subjects involving mathematical calculations d. perceptual problems as a result of poor vision (b) Identification of learning disabilities in children usually occurs: a. in school, after a child has demonstrated difficulty in one or more academic areas b. at birth c. in preschool or day care settings d. in the home (a)

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 6.0	Content	Activities	Time	Pre/Post Questions
Continued				The exact cause of learning disabilities: a. is brain damage which resulted from an accident the mother experienced during pregnancy b. is brain damage during birth process c. is brain damage after birth d. is not known (d) Other factors which influence the child before, during and after birth which may result in learning disabilities are: a. malnutrition and toxic chemicals b. lack of shelter and clothing c. lack of emotional and physical stimulation d. lack of love, warmth, and security (a) Children with learning disabilities often have difficulty with perceptual-motor coordination. true/false (true)

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 6.0	Content	Activities	Time	Pre/Post Questions
Continued				Children with learning disabilities can usually follow two or more directions, but need instruction repeated. true/false (true) Learning disabled children will benefit from activities which emphasize: a. eye-hand coordination b. fine motor skills c. self-help skills d. social, cognitive, language, motor and perceptual-motor skills (d) Rotating activities from passive to active is not good because it focuses the child's energy level in a see-saw manner (up and down) thus confusing the child. true/false (false) One resource available to provide information and/or materials on learning disabilities is: _____

MINI-LECTURE

The Learning Disabled Child

In many cases difficulty in learning can be traced to a specific handicapping condition such as visual or hearing impairments or emotional handicaps. However, for other children problems in reading, writing or math seem to exist without apparent cause; these children are said to have learning disabilities. As defined by PL 94-142:

> *"specific learning disability means a disorder in one or more of the basic psychological processes involved in understanding or using language, spoken, or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing or motor handicaps, or mental retardation, or emotional disturbance, or of environmental, cultural, or economic disadvantage."*

Authorities estimate that 2-3 percent or 1,650,000-2,200,000 of the school aged population suffer from learning difficulties. Because learning disabilities can often be "overcome" as a child matures or with educational intervention, this figure represents a higher percentage of elementary than secondary students. In most cases, the diagnosis of "learning disabilities" is made only after a child has demonstrated difficulty in one or more academic areas, even though he/she may have demonstrated behaviors associated with learning disabilities before that time.

HANDOUT

Causes and Characteristics of Learning Disabilities

Causes

The exact causes of learning disabilities are not known. Learning disabilities can be the result of environmental conditions, heredity, or a combination of the two. Learning problems can result from factors influencing the child before, during, or after birth, such as:

- prolonged high fever
- infectious disease
- toxic chemicals
- hyporia (reduced supply of oxygen to the brain)
- malnutrition or severe protein deficiency, etc.

There is evidence that for some children, difficulties in learning caused by hyperactivity (excessive motor activity) may be caused or accentuated by sensitivities or allergies to certain dyes, preservatives and other additives in food.

Characteristics

There are many indications of learning disabilities which may be identified by teachers, parents and others working in close contact with children. Difficulties in a variety of developmental areas may provide clues to the presence of learning disabilities. These include:

Personal/Social Development

- conflict with other children
- poor body image and self-concept
- immature social behavior
- fear of failure

Cognitive Development

- lag in development in one or more areas of intellectual functioning
- discrepancy between potential intellectual development and actual achievement

Language and Speech Development

- delayed language development
- need for repeated instructions

- inability to follow sequence of two or more directions
- echoes or "parrots" language

Motor Development

- perseveration (repeating same motor movement without changing pattern)
- overactive (unusually high activity level)
- difficulty with gross motor skills
- inability to cross midline of body
- distractable
- difficulty in distinguishing right from left
- handedness not established
- difficulty in fine motor skills
- fearful of heights
- inability to follow motor directions

Perceptual-Motor Development

- visual perceptual problems
- auditory perception problems
- tactually defensive (may not want to be touched, may be very particular about the texture of clothing and food preferred)
- perceptual motor integration problems (unable to understand and coordinate information received through sensory systems)

STIMULATION OF ACTIVITIES WHICH CAN BE USED WITH LD STUDENTS

Trainer:

Divide participants into four groups. Tell participants that they are going to rotate through a series of activities which represent five areas of development (social, intellectual, language/speech, motor and perceptual motor). Some of the activities are passive while others are active, to prevent boredom or over-activity. These activities can be used with LD students (as well as other students).

Personal/Social Activity

Feelings Charade

Materials Needed: 3x5 index cards with "feelings" words such as happy, sad, mad, worried, confused, lonely, hungry, etc., written on them.

(Provides discussion of emotions and behaviors associated with them/promotes association of various emotions with their labels)

Directions for Activity: have each participant in turn, take a word card, read it silently and act out the feeling.

Cognitive/Intellecutal Activity

Let's Count

Materials Needed: felt tip markers; a set of 5x8 index cards with pictures of door knobs, blue eyes, light switches, brown eyes, electrical outlets, etc., on them. Cover with clear plastic.

(Promotes awareness of surroundings/promotes practice in ordering, counting and matching)

NOTE TO TRAINER: If you do not have the above cards for each adult in this group, you can substitute by giving each adult a 3x5 index card with directions telling which item they are to identify in the room. However, stress with the group the necessity of concrete items when doing this activity with LD students.

Directions for Activity: have each participant to count and record the number of objects (they are assigned to identify) in the room. Record the numbers on their cards.

Gross Motor Activity

Follow the Leader Body Movements

Materials Needed: 3x5 cards with questions such as:
how do you move when you get up in the morning?
how do you move when you go up the stairs?
how do you move when you see the bus at your bus stop and you are a half block away?
how do you move when you are jumping rope?
how do you move when you dance to a fast record?
how do you move when you dance to a slow record?
how do you move when you do jumping jacks?
how do you move when you are climbing a ladder?
how do you move when you are washing a car?

(Promotes discussion and demonstration of various body movements)

Directions for Activity: Instruct participants to get in a circle. Place 3x5 cards in the circle. Have each participant, in turn, stand in the circle, pick a card from the top of the stack, read silently and respond to the question by acting out the appropriate behavior. (Trainer should stress that to use this activity in the classroom, the teacher could call out the questions, thus alleviating the need for cards and student reading.) Participants should do the activity for 3-5 seconds.

Language and Speech Activity

Pick and Read

Materials Needed: 3x5 cards with words from common signs, such as: EXIT, CAUTION, LADIES ROOM, MEN'S ROOM, STOP, ENTER, ADMISSION 50¢, SLOW, etc.

(Motivates reading, develops basic sign and word vocabulary, encourages reading for understanding)

Directions for Activity: Participants sit in circle. Each participant, in turn, picks a card from the top of the stack, reads the word and calls another participant to explain what the word or sign means. Encourage calling on different individuals. All should have a turn.

Perceptual-Motor Activity

Do What? How Many?

Materials Needed: 3x5 cards, enough for three stacks of stimulus cards.

(Develops gross motor skills, practice sequencing, associate numbers with concrete actions, match physical activity with verbal instruction, develops body coordiantion)

1st stack directions	2nd stack directions	3rd stack directions include only 1 number on each card such as:
hop	with both hands on head	4 times
jump	w/toes pointed out	3 times
skip	w/arms behind your back	2 times
turn around	w/eyes closed	5 times
sit down	while smiling	2 times
put knees together	with your mouth open	1 time
walk on toes	w/one hand in the air	3 times
	while touching your nose w/both hands	1 time
		4 times

Directions for Activity: Instruct participants to get in a large circle. Each participant, in turn, must draw one card from the top of each stack and do the activity the number of times directed.

EXAMPLE:

stack 1	stack 2	stack 3
HOP ————	WITH BOTH HANDS ON HEAD ——	4 TIMES

Trainer allows five minutes for each activity. Lead large group discussion (problems, variations, etc.) of simulated activities at the completion of simulation.

MINI-LECTURE

Teaching Strategies

Specific strategies used in the education of students with learning disabilities will vary, depending on the nature and extent of the problem. Some children will need assistance in only one area, and may best be served in a regular classroom with added assistance from the resource room teacher. Others, whose disabilities or behavioral problems are more extensive, may do best in a self-contained classrrom in which learning can be highly structured and distractions kept to a minimum. Even in a self-contained classroom, the types of teaching strategies utilized will differ from child to child.

Overall, learning disabled children will benefit from activities which emphasize personal and social skills, cognitive or intellectual skills, language and speech skills, motor skills and perceptual motor skills.

The next handout contains specific strategies for working with students who have learning disabilities.

HANDOUT

Teaching Strategies

Learning disabled children will benefit from activities which emphasize personal and social skills, cognitive or intellectual skills, language and speech skills, motor skills and perceptual motor skills.

Some specific strategies which have proven successful include (Farley, to be published 1982):

- using a variety of methods to reinforce learning behavior--including praise, poems and stories, role simulations, drama, music and art activities, movies, slides, discussions and field trips.
- using concrete visual, auditory and tactile instructional cues.
- rotating active and passive activities to prevent boredom and fatigue.
- varying the length of activities according to attention spans, and limiting work periods to maximize success.
- avoiding drastic change in instructional content; relating one activity to the next.
- reducing distractions; using small groups and clear, quiet work areas.
- remembering that reinforcement should be immediate, consistent and appropriate.
- using printed materials that are dark, clear and adequately spaced--dark print on white background is best.
- using more concrete than abstract ideas.
- speaking softly so the child will listen.
- being calm--try not to show anger, irritation or rejection.
- using physical contact (e.g., a hand on a shoulder) to reduce hyperactivity.
- being firm--make the child perform the tasks he is capable of doing.
- using simple commands or directions.

LARGE GROUP BRAINSTORM

Resources available which provide information and/or materials on learning disabilities.

Trainer instructs group to brainstorm resources which provide information and/or materials on learning disabilities.

HANDOUT

Resources on Learning Disabilities

Association for Children with Learning Disabilities
4156 Library Road
Pittsburgh, PA 15234

American Association of University Affiliated Programs
2033 M Street, Suite 406
Washington, DC 20036

Council for Exceptional Children
Division for Children with Learning Disabilities
1920 Association Drive
Reston, VA 22091

Orton Society
8415 Bellona Lane
Towson, MD 21204

COMPETENCY II:

Develop a General Knowledge of Seven Handicapping Conditions

OBJECTIVE 7.0

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 7.0	Content	Activities	Time	Pre/Post Questions
To identify characteristics, causes, teaching strategies, and resources for working with the visually impaired child.	I. Introduction A. Prevalence B. Definition II. Characteristics III. Causes IV. Teaching Strategies V. Resources	Mini-Lecture: The Visually Impaired Child. Handout: Causes and Characteristics of the Visually Impaired Child. Simulation of Activities. Mini-Lecture: Teaching Strategies. Handout: Teaching Strategies. Brainstorm: Resources. Handout: Resources.	5" 10" 20" 5" 10" 5" 5"	Persons with visual acuity of ____ in their better eye are legally blind. a. 20/70 b. 20/100 c. 20/200 d. 20/400 (c) Visual impairments usually result from injuries or infectious diseases which occur before birth. true/false (false) Most visually impaired children have residual vision. true/false (true) The most common cause of visual impairments are: a. retinal b. cataracts c. refractive errors (myopia, hyperopia, astigmatism) d. dislocation of lens (c) Complaints associated with using the eyes are: a. increased energy and appetite b. headaches, nausea, dizziness

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 7.0	Content	Activities	Time	Pre/Post Questions
Continued				c. loss of energy, aching behind ears d. inability to determine shades of colors (b) Experiences for the visually impaired child should be provided: a. primarily for the development of tactile skills b. primarily for the development of auditory skills c. primarily for the development of gustatory and olfactory skills d. in visual, kinesthetic, tactile, olfactory, gustatory and auditory skills (d) When talking to a visually impaired child, one should pretend that the impairment does not exist. true/false (false) It is not necessary to be consistent in the placement of classroom furniture and materials because the visually impaired child must learn to adjsut to changes also. true/false (false)

Competency II: Develop a General Knowledge of Seven Specific Handicapping Conditions

Objective 7.0	Content	Activities	Time	Pre/Post Questions
Continued				One resource available to provide information and/or materials on visual impairments is: _____

MINI-LECTURE

The Visually Impaired Child

Although severe visual disabilities occur in only a small percentage of the population, the number of persons in the general population who require corrective eyeglasses is high. Very few children of school age will have a visual disability that is severe enough to identify them as blind. The most commonly cited figure is 0.1 percent. Most children with visual problems have from minimal to moderate impairment and are usually able to function independently. They quickly learn to use what sight they have. Most visually impaired children have residual vision; however, if they are not encouraged to use their sight to the fullest capacity, the vision they do have will deteriorate and they will see less.

The National Society for the Prevention of Blindness Fact Book (1966, p. 10) defines visually impaired as follows:

> "blindness is generally defined in the United States as visual acuity for distance vision of 20/200 or less in the better eye, with acuity of more than 20/20 if the widest diameter of field of vision subtend an angle not greater than 20 degrees.
>
> "The partially signted are defined as a person with visual acuity greater than 20/200 but not greater than 20/70 in the better eye with correction."

There are mainly three conditions which may lead to impaired vision. They are:

- reduction of visual acuity (sharpness or clarity)
- limited or defective field of vision
- imperfect color vision

HANDOUT

Causes and Characteristics of Visual Impairments

Causes

Visual problems can be related to a number of identifiable causes. The most common cause of visual impairments is refractive errors such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism (blurred and confusing visual images). These three conditions can become serious visual impairments if left uncorrected, but usually respond well to corrective eyeglasses or contact lenses.

Another cause of visual impairment is lens abnormalities such as cataracts or dislocation of the lens due to head trauma.

Children may be born with or later develop choroid or retinal defects which result in weak and/or disorganized sensations being sent to the brain.

Damage to the optic nerve will also prevent visual messages from accurately reaching the brain.

Other causes of visual impairments and/or blindness include:

- infectious diseases (rubella, syphillis, measles,gonorrhea, tuberculosis, etc.)
- injuries
- poisoning
- tumors
- prenatal influences

Characteristics

Behavior indications of possible vision difficulty:

- body rigidity while looking at distant objects
- thrusting head forward or backward while looking at distant objects
- avoiding close work
- short attention span
- daydreaming
- turning of head so as to use one eye only
- tilting head to one side
- placing head close to book or desk when reading or writing
- frowning or scowling while reading or writing

- excessive blinking
- frequent rubbing of eyes
- closing or covering one eye
- dislike for tasks requiring sustained visual concentration
- nervousness, irritability, or restlessness after maintaining visual concentration
- unusual fatigue after completing a visual task
- losing place while reading
- using finger to keep place while reading
- saying the words aloud or lip reading
- moving head rather than eyes while reading
- difficulty in remembering what is read
- persistent reversals after the second grade
- confusion of similar words
- poor eye-hand coordination
- unusual awkwardness
- frequent movement of the eyeball

Complaints associated with using the eyes:

- headaches
- nausea
- dizziness
- burning or itching of eyes
- blurring of vision at any time

Appearance of the eyes:

- eyes crossed--turning in or out--at any time
- reddened eyes
- watering eyes
- encrusted eyes
- frequent styes

MINI-LECTURE

Teaching Strategies

Since sight is used extensively in most daily living situations and especially in learning situations, it is important that the visually impaired child develop all of his senses to his fullest potential. School personnel will need to provide experiences for the development of the auditory (hearing), tactual (touching), olfactory (smell), gustatory (taste), visual and kinesthetic (muscle and body movements) senses.

The child must develop his/her sense of hearing as keenly as possible in order to succeed in moving about safely and efficiently in the environment. He/she must learn that there are sounds around him, inside of him, and that he can make sounds.

The sense of touch becomes the primary way of learning about the shape, size, position, texture and weight of objects. The child's ability to identify objectives depends heavily on well devleoped tactile skills.

Developing the sense of smell can bring a wealth of useful information to the visually impaired child. Many objects have identifying odors and often the child can identify his environment by the surrounding smells.

The following handout will provide suggestions or strategies for working with the visually impaired student.

HANDOUT

Teaching Strategies

The following suggestions may be very helpful in working with a visually impaired child:

Make the child feel that she/he belongs to the class. Don't give the child special privileges and don't make exceptions in your rules of discipline.

Give the visually impaired child the chance to grow in independence just as you do other children.

Give instructions carefully and be clear in your verbal directions since the visually impaired child may not be able to detect your visual cues.

Prepare materials to allow maximum color contrast like black on white rather than green on yellow or pink. Avoid the use of ditto materials since they tend to be faded and hazy after the first few copies.

Encourage the child to taste, smell, and feel everything possible, not just to look at it.

Provide toys and materials that have a variety of textures on the surface like bumps, sandpaper, corduroy, and screens, as well as smooth plastic.

Instead of pointing to an object, walk over to it and tap or make a noise on the object so the child can hear as well as see the location.

Allow the child to write with a thick tip, black felt pen rather than a pencil.

Talk openly and honestly with the child about his/her vision. Do not either exaggerate the impairment or pretend it doesn't exist.

Provide materials that make noise like balls with bells inside instead of regular balls and toy animals that make sounds instead of stuffed animals.

Remember to focus attention on sounds and smells going on around the child. Occasionally ask questions such as: "What's that sound?" or "What do you smell right now?"

When handing the child an object, actually touch his/her hand with the object rather than holding it out somewhere in front.

Be consistent in your own perfume or cologne so the child can distinguish you from other teachers by your scent.

When teaching a new skill, have the child feel how the skill is done. Have the child put his/her hands on yours and follow along as necessary motions are made.

Talk a lot about what is going on around the child, about feelings, events, and situations.

Be consistent in placement of classroom furniture and materials. If a change is made, be certain the child is shown the change as well as told about it.

Use different textured rugs to announce the approach to important spots such as entrances or exits, bathrooms, sinks, etc. Make sure these rugs are securely fitted to the floor to avoid tripping.

Assign the child the first or last cubby hole, chair, drawer, or coat hanger rather than one in the middle of a large group.

Enable the child to work and play in a well lighted area that is free from glare. Regular light bulbs are easier on a visually impaired child's eyes than flourescent lighting.

Give the child a front seat in the classroom.

A visually impaired child should be encouraged to visually investigate objects in and outside the classroom in order to broaden his visual experience.

Provide real life objects for the child to explore and understand before introducing models of actual things. For example, present a real dog before presenting a model (stuffed animal) of a dog. Last of all present a picture of a dog.

It is necessary to develop language skills so that the child can understand and recognize specific visual cues involving shape, size, position, likeness, difference, etc. Having the words to talk about what she/he sees, will help the child clarify visual impressions and will help adults assist the child more effectively.

When first beginning work with a visually impaired child, allow short periods of time (5-15 minutes) for visual stimulation activities. The length of time can be gradually increased as the visual activities become less tiring for the child.

Initially, all materials should be large enough for the child to see easily and quickly. Size can be reduced gradually as long as the child continues to be successful at the visual activities.

LARGE GROUP BRAINSTORM

Resources available which provide information and/or materials on visual impairments.

Trainer instructs groups to brainstorm resources which provide information and/or materials on visual impairments.

HANDOUT

Resources Available Which Provide Information and/or Materials on Visual Impairments

American Foundation for the Blind
15 West 16th Street
New York, NY 10011

American Printing for the Blind
1839 Frankford Avenue
Louisville, KY 40206

National Society for the Prevention of Blindness, Inc.
70 Madison Avenue
New York, NY 10016

The Council on Exceptional Children
Division for Children with Visual Impairments
1920 Association Drive
Reston, VA 22091

RESOURCES

Bookbinder, Susan. Mainstreaming: What Every Child Needs to Know About Disabilities. Providence: The Rhode Island Easter Seal Society, 1978.

Federal Register, Vol. 42, No. 163, PL 94-142: Education of All Handicapped Children Act of 1975.

Gearheart, Bill. Special Education for the '80s. St. Louis: The C. V. Mosby Company, 1980.

Haring, N. G. and Phillips, E. L. Analysis and Modification of Classroom Behavior. Englewood Cliffs, New Jersey: Prentice Hall, 1972.

94-142 and 504: Numbers that Add Up to Educational Rights for Handicapped Children. Washington, DC: Children's Defense Fund of the Washington Research Project.

Semrau, Barbara. Teaching Every Child: A Guide for Writing Individualized Programs. Jonesboro, Arkansas: Focus of Children, 1979.

Special Needs of the Young Exceptional Child. Anchorage, Alaska: Easter Seal Society for Alaska Crippled Children and Adults, 1977.

- Mental Retardation
- Hearing Disabilities
- Language Disabilities
- Social and Emotional Disabilities

Tips on Mainstreaming: Do's and Don'ts in Activity Programs. Washington, DC: American Alliance for Health, Physical Education and Recreation, Vol. 1, No. 10, March 1978.

When You Care for Handicapped Children. Austin, Texas: Texas Department of Human Resources, 1979.

APPENDIX A

Supplemental Resources

Supplemental Resources

HANDICAPPING CONDITIONS

General

Books

Early Self-Help Skills: Steps to Independence: A Skills Training Series for Children with Special Needs

Bruce Baker

Intended for parents of children with special needs, the manual provides basic techniques in teaching early level self-help skills, such as eating, grooming, and dressing through behavior modification.

Research Press

Reading in the Psychology of Exceptional Children

Herbert Goldstein

Provides selected reading in these areas: Special Education, Mental Retardation, Learning Disabilities, Autism, Behavior Modification, Mainstreaming, Emotional and Behavioral Disorders, Speech and Hearing, Deaf and Visually Handicapped Education, Dyslexia, Physically Handicapped Education, and Gifted/Talented Education.

Special Learning Corporation 575 pp 1978

Dictionary of Special Education

Orm D. Parashar

Provides technical definitions for multidisciplinary professionals and parents in order to facilitate their communication in the area of special education.

Educational Activities 117 pp 1977

Early Childhood Education for Exceptional Children

June B. Jordan, Alice H. Hayden, et al.

Handbook of ideas and exemplary practices developed out of the First Chance Program, which created demonstration models for public schools and other agencies who need information on how to provide a variety of kinds of help to handicapped children and their families.

Council for Exceptional Children 310 pp 1977

Audiovisuals

FILMSTRIPS

Approaches to Mainstreaming—Teaching the Special Child in the Regular Classroom
Units I and II
A series of training filmstrips that provide information and practical suggestions to help regular classroom teachers meet the needs of the special students in their classrooms. The Unit I series contains the four specific filmstrips: Individual Differences; Characteristics of Children with Special Needs; Organizing Your Classroom; Handling Behavior Problems. Unit II contains Selecting Materials; Adapting Materials; Modifying Your Instructions; and Evaluating Your Instruction.

Teaching Resources Corporation 1976

Creating Instructional Materials for Handicapped Learners
Shows teachers how to create materials for teaching handicapped learners, and guides teachers in selecting, evaluating, adapting, and using commercial materials for educating handicapped children.

National Audiovisual Center filmstrips/cassettes 1974

A Walk in Another Pair of Shoes
This filmstrip, narrated by Tennessee Ernie Ford, explains some of the problems encountered by learning disabilities of children to other children. The emphasis is on how it feels to be a handicapped child and how a normal child can be of assistance to a handicapped child.

CANHC Film Distribution
Sale: consult distributor filmstrip color 18-1/2 min.

A Special Need, A Special Love: Children With Handicaps, Families Who Care
The problems and potential of handicapped children, specifically, the help and support the family requires; how family members can help one another in working with the handicapped child, and the services available for educators, the helping professions, and the community.

Parents' Magazine Films, Inc. filmstrips/cassettes 1976
$200.00

Project Me
A full-service program to provide comprehensive awareness and training for teachers of preschool handicapped children (ages 3-5).

Six modules include cassettes/filmstrips, games, roleplay, and various print material, including actual classroom materials. The six modules are the following:

1. Why Me? awareness, attitude training
2. Assess Me. assessment, classroom testing
3. Place Me. Interdisciplinary and administrative approaches and problems of placement
4. Teach Me. communication and counseling training for teachers
5. Parent Me. communication and counseling training for teachers and parents
6. Accept Me. an advocacy model for student and teachers.

Education Service Center filmstrips/print materials/cassettes
Sale: $260.00

RECORDS

Special Children

An overview of the field of exceptionality and an introduction to the area of special education. Presents the special child as an individual more normal than abnormal in his desire for life and learning.

Media 1972 30 min.

FILMS

Cynthia Dresses Herself

Content is aimed at parents and teachers of handicapped children. It demonstrates learning principles for teaching specific behavior.

Teaching Research Division color 16 mm 10 min.

Evaluation by the School Psychologist

Explains the process of evaluation of a student by a school psychologist. The evaluation procedure is traced from the teacher's referral of a student to the acquisition of the special education help needed by the pupil.

Instructional Media Services 20 min.

Looking At Children

An excellent film that portrays the early signs of health problems and conditions in children as seen by observant teachers. "Looking for Health" booklet is supplementary to this film.

Metropolitan Life Insurance Company color 16 mm 24 min.

Maybe Tomorrow

Shows how and why certain methods are used to help blind, deaf, retarded and crippled children improve their coordiantion, increase self-confidence and achieve their highest potential.

AIM for the Handicapped 26 min.

Nobody Took the Time

Preschool program for disadvantaged children who are ineligible for Head Start or other preschool programs because of developmental problems, such as brain damage, mental retardation, emotional disturbance or social maladjustment. These children are functionally retarded. Belle Bubnoff, and other staff members demonstrate and discuss activities and problems found in working with these children through social interaction, play, language, feeding, etc. This is a pilot program for young ghetto children having a typical problem. Good for teachers, parents, agencies, administrators.

Dubnoff School for Educational Therapy b/w 16 mm 20 min.

Play Learning Centers for Preschool Handicapped Children

A visual report of a BEH-funded research and demonstration project involving the design, construction, and evaluation of three play learning centers for preschool handicapped children. The play behaviors of children with a variety of developmental needs is shown in each of the innovatively designed play centers.

Division of Educational Resources 30 min.

Emotionally Impaired

Books

Behavior Disorders in Children

Harvey F. Clarizio, George F. McCoy

Evaluates some accepted facts, theories, principles about disturbed children and adolescents; presents vignettes of children with point-by-point summaries to assist students. Also discusses issues associated with normal development.

Thomas Y. Crowell 596 pp 1976

Audiovisuals

FILMS

Aggressive Child

The purpose of this film is to show that serious emotional problems often underlie difficult or puzzling behavior in children. It illustrates how parents' feelings and attitudes influence children's emotional development and behavior, with particular emphasis on the importance of experiences in early infancy on children's growth and emotional life. Play therapy and other modern techniques in psychotherapy, counseling, and special education are illustrated in a variety of ways.

National Association for Mental Health b/w 16 mm 28 min.

Lonely Night

Deals with the mental turmoil of an emotionally unbalanced person, the nature and function of psychiatric treatment, and the quality of parent-child relationships that results in mental well-being. Pictures reactions to loneliness in different people and follows the psychiatric treatment of a young woman who seeks to overcome her fear of loneliness. Identifies simultaneously through a series of family experiences the nature of child care that leads to the development of good mental health.

National Association for Mental Health b/w 16 mm 65 min.

Who Is This Child?

Who is emotionally disturbed? How do we define those who are emotionally disturbed? How do we find that child in the school or home? These questions are investigated in the film by employing techniques of case study. The difficulties of forming a definition for the term "emotionally disturbed" that will be satisfactory in every case, and the problems of constructing a working description by which a child is identified, are further elaborated upon by the discussion panel.

New York State SEIMC b/w 16 mm 30 min.

Learning Disabilities

Audiovisuals

FILMS

Early Recognition of Learning Disabilities

Children who have learning disabilities stand out vividly in daily classroom activities during their early school years, as do their

problems. Interviews with parents and teachers emphasize that it is urgent to recognize learning disabilities early and provide extra teaching needed in time to achieve full educational potential.

National Audiovisual Center color 16 mm 30 min.

Teaching the Way They Learn: Remediation of Learning Disabilities

This film has been prepared primarily for teachers of young trainable children. Its purpose is to illustrate a classroom climate and suggest teaching and training techniques which have been found helpful in stimulating maturation, and encouraging the growth of communication skills in mongoloid children at the primary school level.

Harris County Center for the Retarded, Inc. b/w 16mm 27 min.

Books

Behavior Modification of Learning Disabilities

Robert H. Bradfield

Presents the general application of behavior modification in educational and social environments; its use in remediation of learning disabilities; model programs and curriculum.

Academic Therapy 172 pp 1977

Developmental and Learning Disabilities

John H. Meir

Contains extensive explanation of normal development and learning as well as disabilities in development and learning. Offers in-depth report of prevention, detention, intervention, and evaluation procedures.

University Park Press 444 pp 1976

Other Health Impairments

Audiovisuals

VIDEOCASSETTES

Tim Talks About Epilepsy

An explanation of what happens in the brain and body to cause seizures. A comparison of epilepsy with such other bodily misfunctions as hearing and eyesight problems, allergies, etc. Emphasizes use of medicine to control seizures.

Farrago Information Systems 8 min.

FILMS

Chronic Disorders

Discusses the special problems confronting the child with a chronic disorder such as hemophilia. Explains various types of chronic disorders and points out how social and emotional growth is complicated by a chronic illness. Shows how educational training is provided for some children with chronic disorders.

Indiana University AV Center b/w 16 mm 29 min.

Epileptic Seizure Patterns

Uses original artwork to show historical aspects of epilepsy and various types of epileptic seizures in actual patients. Shows and explains electroencephalography tracings in a normal man and uses a split frame technique to compare normal tracings with those of grand mal, petit mal, automatism, myoclonic, psychomotor, and mixed adverxive-grand mal patients.

Indiana University AV Center color, b/w 16 mm 25 min.

Multiply Handicapped Children

The film aims to demonstrate the educational evaluation of preschool children with single and multiple handicaps. Through the use of graded tests and their flexible presentation it enables children with various handicaps in expression to respond, if necessary without the use of speech or manipulation. The following three cases are shown: a blind child, a child with cerebral palsy, and a hyperactive child.

United Cerebral Palsy Association color 16 mm 30 min.

Orthopedically Impaired

Audiovisuals

FILMS

Billy

Documentary about care and treatment of cerebral palsied child.

United Cerebral Palsy Association color 16 mm 15 min.

Bobath Approach to Cerebral Palsy Habilitation

Illustrates normal sequential growth and development of reflex actions and methods used to initiate these in cerebral palsied children.

Newington Hospital for Crippled Children color 16mm 30 min.

Physiological Aspects of Speech—Speakers with Cerebral Palsy

This film shows the characteristics and types of cerebral palsy and the speech problems resulting from neuro-muscular deficiencies. Comparisons between normal speech patterns and speech patterns of children with various forms and stages of cerebral palsy are shown. Technical functionings in the speech processes explained.

University of Iowa color 16 mm 25 min.

The Cerebral Palsied Child

Discusses the special problems faced by the child with cerebral palsy and explains how physical disability, psychological problems, mental subnormality, and the great number of clinical types adds to the complexity of this affliction. Features Dr. William Cruickshank of Syracuse University.

Indiana University AV Center b/w 16 mm 29 min.

Books, Booklets

A Handbook of Medical, Educational, and Psychological Information for Teachers of Physically Handicapped Children

Harold D. Love, Joe E. Walthall

Presents medical, educational and psychological information especially designed for teachers, teacher-trainers, and the parents of physically handicapped children.

Charles C. Thomas 219 pp 1977

Program Guidelines for Children with Feeding Problems

Suzanne Evans Morris

Practical guide to behavioral management of problems associated with the feeding of disabled children; explicit photographs, simple directions; treat both physiological and psychological deficits.

Childcraft 48 pp 1977

Dancing Games for Chidren of All Ages

Ester L. Nelson

Gives clear and detailed instructions for teaching dances for special occasions and special children (mentally and physically handicapped).

Sterling 72 pp 1976

Physical Activities for the Handicapped

Maryhelen Vannier

Offers a wide range of physical activities; stresses their importance in rehabilitation and education; gives excellent synopsis of each

handicapping condition and the physical activities most appropriate. Contains methods and skills for teaching the handicapped through physical activities. Presents camping and outdoor activities.

Prentice Hall 338 pp 1977

Teaching Individuals with Physical and Multiple Disabilities
June L. Bigge
Designed for teachers, consultants, supervisors, and others who teach and develop curriculum for individuals with physical and multiple disabilities.

Charles E. Merrill 279 pp 1976

Audiovisuals—General

Madison Plan
The film illustrates the implement action of the Madison School Plan in the Santa Monica School District. The project involves handicapped children who would traditionally be labeled EMR, ER, LD, visually impaired and auditorily impaired. This plan provides the education of these kids in a setting allowing free flow of children between the regular classes and the specialized facility (Learning Center).

AIMS Instructional Media Services, Inc. color 16 mm 18 min.

One Step at a Time
Shows how positive reinforcement works—in form of praise, warm physical contact, tokens, charts and graphs, and other rewards—and how it encourages handicapped or retarded children, children with learning problems, or disturbed adults to respond with appropriate behavior.

McGraw Hill color 1973 30 min.

Mentally Retarded

Books

An Introduction to Mental Retardation: A Programmed Test
Walter E. Ehlens, Curtis H. Krishef, John C. Prothero
Written as a basic introductory text for persons just entering the fields of special education, social workers in agencies that serve the retarded, teachers, and others involved in staff training; may be

used as a "self-instructional" text or in a conventional class.

Charles E. Merrill Publishing Company 384 pp 1977

Helping the Mentally Retarded to Acquire Play Skills: A Behavioral Approach
Paul Wehman
Describes how behavioral training methods may be applied to the play problems of the mentally retarded, provides specific instructional directions, and program guidelines; addresses the leisure-time needs of all ages, and functioning levels of the mentally retarded.

Charles C. Thomas, Publisher 1977

Audiovisuals

VIDEOTAPES

The Mentally Retarded Child
Discusses various types of retardation along with a case study. Also the education methods available to the retarded child along with counseling and guidance is covered.

Videorecord Corp. of America b/w 1972 44 min.

FILMS

Another Kind of School
Demonstrates modern methods of teaching and training mentally handicapped children between ages of five and sixteen.

SWS Educational Films color 16 mm 25 min.

Educable Mentally Handicapped
Discusses the special problems of educable mentally handicapped children. Explains who they are, the problems they face in the community and the school, and what can be done to help them. Uses still photos and filmed sequences of a special class for these children to show the place of the school in meeting the needs of the mentally handicapped.

Indiana University AV Center b/w 16 mm 29 min.

First Steps
Emphasizes the importance of early stimulation and training for educably retarded children, and explores the rationale for integrating them into regular school systems rather than separate

institutions. Some of the particular needs and overlooked competencies of handicapped children are clearly shown, and the benefits of integrating such children into normal classroom situations becomes obvious.

CRM/McGraw Hill Films 24 min.

Methods of Teaching Art to the Mentally Retarded

Shows teaching techniques in art for the retarded child.

Indiana University AV Center color 16 mm 34 min.

Multilevel Teaching for Normal and Handicapped Children

Demonstrates some techniques used by teachers to provide individual instruction to small groups of children who vary greatly in their individual skill levels; filmed in an experimental classroom in the Kansas Center for Mental Retardation and Human Development.

University of Kansas Film Rental Services 29 min.

Report on Down's Syndrome (Mongolism)

A comprehensive statement of Down's Syndrome, previously called Mongolism, from its first description by the British physician Langdon Down in 1866. Outlines general characteristics and treatment methods, including latest finding in the area of genetics. The advantages and rewards of warm family life and application of the routine-relaxation-repetition formula are illsutrated.

International Film Bureau color 16 mm 21 min.

The Shape of a Leaf

Demonstrates the significance of art education in the training of retarded children and explores the possibilities of teaching them skills, enhancing their perception, and improving their coordination. Instead of concentrating on particular ways to teach the retarded students, ages seven through 19, working on their materials and each student explaining his own work.

Campbell Films color 16 mm 26 min.

Who Are the Winners?

This film is based on the Milwaukee Project, a study of a preventive approach to cultural familiar retardation. The project, a research program designed by Dr. Rick Herber, and staff, has implication for those concerned with the mentally retarded and with the relationship between poverty and mental retardation. Although the long range effects of this program are still unknown, the film and the

findings upon which it is based suggest that a large percentage of cultural familial retardation can be prevented through an enriched early learning program.

University of Wisconsin — color — 16 mm — 20 min.
Bureau of AV Instruction

Why Billy Couldn't Learn

This film shows neurologically handicapped children in authentic classroom and playground situations. Shows why neurologically handicapped children need special education help, and how they receive it in the educationally handicapped program. It is one of the best films in this area and the teaching methods and techniques are of special interest. The film is accompanied by a seventeen page study guide.

CANHC Movie Distribution — color — 16 mm — 40 min.

Aids for Teaching the Mentally Retarded Series

Phase A: Motor Training

Unique devices and exercises stimulate the passive child to initiate activities and help him to understand cause and effect relationships.
Sale: $132.00 rental: $5.00 color 16 mm 11 min.

Phase B: Initial Perceptual Training

Exercises involving various sensory areas are provided to help improve perceptual skills.
Sale: $90.00 rental: $5.00 color 16 mm 7-1/2 min.

Phase C: Advanced Perceptual Training

Building upon previous exercises, new experiences are provided that help the student to make decisions and draw conclusions.
Sale: $108.00 rental: $5.00 color 16 mm 9 min.

Phase D: Integrated Motor-Perceptual Training

This stage includes activities that integrate movement and perception.
Sale: $77.00 rental: $5.00 color 16 mm 6 min.

Phase E. Sheltered Workshop

Actual work experiences, adjusted to the levels of their abilities are offered to students in the training phase of the sheltered workshop program.
Sale: $65.00 rental: $5.00 color 16 mm 5 min.

Thorne Films, Inc. Sales
Bureau of AV Instruction Rental

Teaching the Mentally Retarded Through Music

In each of the four presentations, Dr. Richard Weber explains and demonstrates his approach to teaching the mentally retarded through music. He shows how music becomes a motivator for developing writing and reading skills as well as a stimulus for better self-control.

Governor's Interagency Council on Mental Retardation — b/w — 16 mm — 30 min.
Sale and Rental: Consult distributor

Severely Handicapped

Films

Cast No Shadow

Vividly depicts a wide variety of recreation activities for severely mentally retarded, physically handicapped and emotionally disturbed children, teens and adults at the nationally recognized Recreation Center for the Handicapped, Inc. in San Francisco.

Professional Arts, Inc. — color — 16 mm — 29 min.

Books

Teaching the Moderately and Severely Handicapped, Vol. I

Michael Bender, Peter J. Valletutti

Presents a curriculum of functional academics in reading, writing, arithmetic, consumer skills; includes objectives, activities, and strategies, for therapeutic programs.

University Park — 361 pp — 1976

Teaching the Moderately and Severely Handicapped, Vol. II

Vol. II Communication, Socialization, Safety, Leisure Time Skills

Michael Bender, Peter J. Valletutti, Rosemary Bender

Behaviorally oriented, specific-directed activity handbook for activities that reinforce socially acceptable skills and prepare for leisure activities.

University Park — 420 pp — 1976

Visually Impaired

Books, Booklets

The Blind Child in the Regular Kindergarten

Josephine Stratton

Reviews the literature on the learning behavior of the blind child. Gives a specific teaching guide, indicating by code which curricula need no adapting, which require some changes, and which are entirely inappropriate.

Charles C. Thomas 88 pp 1977

Audiovisuals

VIDEOCASSETTES

Special Aids for the Visually Handicapped

The probability of a regular classroom teacher having a visually handicapped student is increasing significantly. Designed to illustrate some of the special aids and resources available for both student and teacher, when in a regular classroom. The visually handicapped are being encouraged to take every advantage of regular education programs.

State University of New York at Brockport 30 min.

RECORDS

Days of Shadow

Story of special children who live in a world of shadows and partial sight. Provides information concerning the social, education, and emotional needs of visually handicapped.

Media 30 min. 1972

Before We Are Six

An updated film to prepare professionals and volunteers to screen the vision of preschool and school children.

National Society for Prevention of Blindness, Inc. color 16 mm 22 min.

Blinded Chidren in Sighted Physical Education Classes

This films shows several situations in which blind children participate in regular physical education classes with sighted children in elementary and junior high schools in DeKalb, Illinois. Physical coordination, behavior typical of blind children, and techniques used in assisting them in physical activities with normal children of the same age are demonstrated. The film also focuses on attitudes of blind children and their acceptance by sighted children in the regular program.

Northern Illinois University b/w 17 mm 20 min.

FILMS

Bus Travel

Dependence upon others for getting from one place to another is one of the greatest handicaps for the blind. Learning orientation and mobility skills greatly minimize that limitation. This film demonstrates a number of the specific orientation and mobility skills which blind persons need if they are to use public transportation. Blind children are shown learning a sequence of bus travel skills, starting with concept building and concluding with a "solo run."

Alameda County School Department color 16 mm 13 min.

Eyes and Their Care

Examines the eye in terms of structure, functions, disorders, and hygiene. Reveals, with animated drawings, the various parts of the eye and explains the physiology of sight. Illustrates such eye defects as nearsightedness, farsightedness, and astigmatism, and describes their correction with proper glasses. Calls attention to eye infections, the removal of foreign bodies, and damage by radiation.

Encyclopedia Britannica Educational Corporation b/w 16 mm 11 min.

Not Without Sight

Defines the major types of severe visual impairments, examines their causes and illustrates how those with visual impairments function. It was produced to answer the need made by those in the field of blindness for a film which might help to dispel some of the stereotypic thinking sighted people have about blindness and other forms of severe visual impairments.

American Foundation for the Blind 16 mm color 1973 19-1/2 min.

Visual Perceptions and Failures to Learn

Depicts difficulties in learning for children who have disabilities in visual perception. Demonstrates the Marianne Frostig test and outlines a training program.

AIMS Instructional Media Services, Inc. b/w 16 mm 20 min.

The Visually Handicapped Child, the Blind

Discusses the special problems encountered by the child who is blind, and explains the care and understanding needed in order to enable the blind child to develop and to participate in the

relationships of life. Illustrates the limitations imposed by blindness, and describes materials and techniques used in the education of the blind.

National Educational Television b/w 16 mm 29 min.
Indiana University AV Center

APPENDIX B

Distributors for Books and Audiovisuals Listed in the Module

APPENDIX B

Distributors for Books and Audiovisuals on Special Education*

ACI Productions, Inc.
35 West 45th Street
New York, NY 10036

AIMS Instructional Media Service, Inc.
P.O. Box 1010
Hollywood, CA 90028

Academic Therapy Publications
P.O. Box 899
1539 Fourth Street
San Rafael, CA 94901

Acme Film Labs, Inc.
1161 North Highland Avenue
Hollywood, CA 90038

Alameda County School Department
Orientation-Mobility Project
224 West Winton Avenue
Hayward, CA 94544

Alexander Graham Bell
Association for the Deaf
3417 Volta Place
Washington, DC 20007

Allyn and Bacon, Inc.
470 Atlantic Avenue
Boston, MA 02210

American Foundation for the
Blind, Inc.
15 West 16th Street
New York, NY 10011

BFA Educational Media
P.O. Box 5467
Church Street Station
New York, NY 10249

Bank Street Films
[illegible] West 25th Street
New York, NY 10001

Behavior Modification
Technology, Inc.
Box 597
Libertyville, IL 60048

Bemidji State University
Child Development Training
Program
Bemidji, MN 56601

CRM Educational Films
220 Twelfth Street
Del Mar, CA 92014

Campbell Films
Academy Avenue
Saxtons River, VT 05154

Campus Film Distributors, Inc.
20 East 46th Street
New York, NY 10017

Chapel Hill-Carrboro City
School System
Lincoln Center
Chapel Hill, NC 27514

Child Welfare League of
America, Inc.
67 Irving Place
New York, NY 10003

Childcraft Education
20 Kilmer Road
Edison, NJ 08817

Columbia University Press
136 South Broadway
Irvington, NY 10533

Contemporary Films/
McGraw Hill
1221 Ave. of the Americas
New York, NY 10020

Council for Exceptional Children
1920 Association Drive
Reston, VA 20291

Crowell, Thomas Y., Inc.
10 East 53rd Street
New York, NY 10022

Davidson, Robert
Apt. 1-E
257 W. 10th Street
New York, NY 10014

Dell Publishing Company
1 Dag Hammarskjold Plaza
New York, NY 10017

Dubnoff School for Education Therapy
10526 Victory Place
North Hollywood, CA 90038

Easter Seal Society for Alaska Crippled Children and Adults
726 E Street
Anchorage, AK 99501

Education Service Center
Region XIII
7703 N. Lamar
Austin, TX 78752

Educational Activities, Inc.
1937 Grand Avenue
Baldwin, NY 11510

Encyclopedia Britannica Educational Corporation
425 N. Michigan Avenue
Chicago, IL 60611

Far West Laboratory for Educational Research and Development
1855 Folsom Street
San Francisco, CA 94103

Gryphon House
Box 76108
Birmingham, AL 35223

Harper and Row Publishers
10 E. 53rd Street
New York, NY 10022

Harris County Center for the Retarded, Inc.
P.O. Box 13403
Houston, TX 77019

High Scope Educational Research Foundation
Instructional Media Services
600 N. River Street
Ypsilanti, MI 48197

Holt, Rinehart & Winston, Inc.
383 Madison Avenue
New York, NY 10017

Indiana University
Audio-Visual Center
Bloomington, IN 47401

International Film Bureau
332 South Michigan Avenue
Chicago, IL 60604

Irvington Publishers, Inc.
551 Fifth Avenue
New York, NY 10017

Knowledge Builders
Visual Education Building
Lowell Ave. & Cherry Lane
Floral Park, NY 11011

Lexington School for the Deaf
30th Avenue & 75th Street
Jackson Heights, NY 11370

McGraw Hill Book Company
P.O. Box 37439
San Francisco, CA 94137

McGraw Hill Book Company
P.O. Box 402
Highstown, NJ 08520

McGraw Hill Films
1221 Avenue of the Americas
New York, NY 10020

Media Five Film Distribution
1001 N. Cole Avenue
Hollywood, CA 90038

Charles E. Merrill
Publishing Company
Columbus, OH 43216

Metropolitan Life Insurance Co.
Health and Welfare Division
1 Madison Avenue
New York, NY 10010

Michigan State University
Competency-Based Teach Education
East Lansing MI 48823

Modern Talking Picture Service
Film Libraries
c/o Buchan Pictures
122 West Chippewa Street
Buffalo, NY 14202

Modern Talking Picture Film
Library, Suite 4
200 L Street N.W.
Washington, DC 20036

Mosby, C.V., Company
11830 Westline Industrial Drive
St. Louis, MO 63141

National Association for the
Education of Young Children
1834 Connecticut Avenue N.W.
Washington, DC 20009

National Association for Mental
Health
1800 N. Kent Street
Rosslyn, VA 22209

National Audiovisual Center
National Archives and Records
Service
Washington, DC 20409

New York University Film
Library
26 Washington Place
New York, NY 10003

Newington Hospital for Crippled
Children
Newington, CT 06111

Northern Illinois University
Audio Visual Center
De Kalb, IL 60115

Ohio State University Film
Library, Department of
Photography and Cinema
156 West 19th Avenue
Columbus, OH 43210

Parent Magazine Films, Inc.
Box 1000
Elmsford, NY 10523

Pennsylvania State University
Continuing Education Stores
Room 7
J. Orvin Feller Building
University Park, PA 16802

Prentice-Hall Film Library
College Division
Prentice Hall, Inc.
Englewood Cliffs, NJ 91608

Research Press
Box 31779
Champaign, IL 61820

SWS Educational Films
3031 Kallin Avenue
Long Beach, CA 90808

Special Learning Corporation
42 Boston Post Road
Guildford, CT 06437

Special Purpose Films
26740 Latigo Shore Dr.
Malibu, CA 90265

State University of New York
at Buffalo
4242 Ridge Lea Road
Amherst, NY 14226

Sterling Publishing Company
412 Park Avenue South
Oak Tress Co., Ltd.
London, NY 10016

Teaching Resources Corp.
100 Boylston Street
Boston, MA 02116

Charles C. Thomas
301-327 E Lawrence Ave.
Springfield, IL 62717

University of Iowa
Audio-Visual Center
Division of Extension and
University Service
Iowa City, IA 52240

University of Kansas
Film Rental Services
746 Massachusetts St.
Lawrence, KS 66044

University of Michigan
A-V Education Center
416 Fourth Street
Ann Arbor, MI 48103

University Park Press
Chamber of Commerce Bldg.
Baltimore, MD 21202

University of State of New York
Education Department
Division of Handicapped Children
Albany, NY 12224

Time-Life Films, Inc.
100 Eisenhauer Drive
Paramus, NJ 07652

Total Communication Laboratory
Western Maryland College
Westminster, MD 21157

USC Special Order Department
and Bookstore
University of Southern California
University Park
Los Angeles, CA 90007

United Cerebral Palsy Assn., Inc.
Professional Svcs. Program Dept.
66 East 34th Street
New York, NY 10016

Univ. of California Extension
Public Film Rental Library
2223 Fulton Street
Berkeley, CA 94720

University of California at
Los Angeles
Film Library
Los Angeles, CA 90024

University of California Press
1414 South 10th Street
Richmond, CA 94804

University of Texas
Visual Instruction Bureau
Drawer W University Station
Austin, TX 78712

University of Washington
Experimental Education Unit
Seattle, WA 98105

University of Wisconsin
Bureau of AV Instruction
1327 University Avenue
Madison, WI 53701

Wayne State University
A-V Productions Center
680 Putnam
Detroit, MI 48202

Wilkerson, Bill
Hearing and Speech Center
Division of Language Development Programs
114 Nineteenth Avenue, South
Nashville, TN 37212

Wright, Bradley Films
309 N. Duane Avenue
San Gabriel, CA 91775

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*Adapted for the PEG Program, SKILLBANK, Social Sciences Division, Burlington County College, Pemberton, New Jersey 08068.